

310-GG - NUTRITIONAL THERAPY, METABOLIC FOODS, AND TOTAL PARENTERAL NUTRITION

EFFECTIVE DATES: 10/01/15, 11/27/18, 07/20/23

APPROVAL DATE: 09/20/18, 05/25/23

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, and DES/DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), DES/DDD Tribal Health Program (DDD THP), and Tribal ALTCS; excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements regarding nutritional assessments, nutritional therapy, including metabolic medical foods, commercial oral supplements, and total parenteral nutrition for members 21 years of age and older.

For members 20 years of age and under, refer to AMPM Policy 430 for EPSDT requirements specific to nutritional assessments and nutritional therapy,

II. DEFINITIONS

Refer to the [AHCCCS Contract and Policy Dictionary](#) for common terms found in this Policy including:

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)	MEMBER	PRIMARY CARE PHYSICIAN (PCP)
PRIOR AUTHORIZATION (PA)		

For purposes of this Policy, the following terms are defined as:

COMMERCIAL ORAL SUPPLEMENTAL NUTRITION

Nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

ENTERAL NUTRITION

Liquid nourishment provided directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by Jejunostomy Tube (J-Tube), Gastrostomy Tube (G-Tube) or Nasogastric N/G Tube).

**METABOLIC MEDICAL FOOD
FORMULAS OR MEDICAL FOODS**

Nutrition and specialized diets used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. In order to avoid toxic effects, the treatment of the associated metabolic disorder depends on dietary restriction of foods containing the substances that cannot be metabolized by the member.

**TOTAL PARENTERAL
NUTRITIONAL(TPN) THERAPY**

Nourishment provided through the venous system to members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling catheter.

III. POLICY

A nutritional assessment is required for a member who has been identified as having a health status which may improve or be maintained with nutrition intervention such as nutritional therapy.

The Contractor and FFS Programs cover nutritional assessments as determined medically necessary and as a part of health risk assessment and screening services provided by the member's Primary Care Provider (PCP). Nutritional assessment services provided by a registered dietitian also are covered when ordered by the member's PCP.

The Contractor and FFS Programs cover nutritional therapy on an enteral, parenteral, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake. AHCCCS adheres to Medicare requirements for the provision of Total Parenteral Nutrition (TPN) services.

For medically necessary Women, Infants, and Children (WIC)-exempt formula, the Contractor or FFS provider shall also be responsible for procurement of and the primary funding source for any other nutritional supplementation that is medically necessary.

The Contractor and FFS Providers shall implement protocols for transitioning a member who is receiving nutritional therapy to or from another Contractor or provider.

A. PRIOR AUTHORIZATION

Prior Authorization (PA) from the Contractor, the Tribal ALTCS case manager, or the AHCCCS Division of Fee-For-Service Management (DFSM) is required for commercial oral nutritional supplements, enteral nutrition, and parenteral nutrition unless:

1. The member is currently receiving nutrition through enteral or parenteral feedings for which PA has already been obtained.
2. For the first 30 days with members who require oral supplemental nutritional feedings on a temporary basis due to an emergent condition, e.g., post-hospitalization.

B. COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Medical necessity for commercial oral nutritional supplements shall be determined on an individual basis by the member's PCP or specialty provider, using the criteria specified in this Policy. The PCP or specialty provider shall use the AHCCCS approved form (Attachment A) to obtain authorization from the Contractor (and ALTCS case manager, if applicable) or the DFSM for FFS members.

1. Specific criteria shall be met utilizing Attachment A when assessing the medical necessity of providing commercial oral nutritional supplements. The criteria includes the following:
 - a. The member is currently underweight with a Body Mass Index (BMI) of less than 18.5, presenting serious health consequences for the member, or has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment),
 - b. The member is able to consume/eat no more than 25% of their nutritional requirements from typical food sources,
 - c. The member has been evaluated and treated for medical conditions that may cause problems with weight gain and growth (e.g., feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems), and
 - d. The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the member's overall health, the provider shall submit Attachment A, along with supporting documentation demonstrating the risk posed to the member from the Contractor's Medical Director or Designee's consideration in approving the provider's PA request.

2. Supporting documentation shall also accompany Attachment A. This documentation shall demonstrate that the member meets all the required criteria and includes:
 - a. Initial Requests:
 - i. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the Primary Care Provider (PCP) or specialty provider, or through consultation with a registered dietitian,
 - ii. Clinical notes or other supporting documentation dated no earlier than three months prior to date of the request, providing a detailed history and thorough physical assessment and demonstrating evidence of the member meeting all of the required criteria listed in Attachment A. The physical assessment shall include the member's current/past height, weight, and BMI, and
 - iii. Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/alternatives attempted.
 - b. Ongoing Requests:
 - i. Subsequent submissions shall include a clinical note or other supporting documentation dated no earlier than three months prior to the date of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This shall include the member's tolerance, recent hospitalizations, current height, weight, and BMI,
 - ii. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate,
 - iii. Members receiving nutritional therapy shall be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually, and
 - iv. Initial and ongoing certificate of medical necessity is considered valid for a period of six months.

C. METABOLIC MEDICAL FOODS

Metabolic medical foods are used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder.

1. Metabolic formulas and medical foods are covered for members diagnosed with metabolic conditions that are screened for on the Newborn Screening Panel. Refer to Arizona Department of Health Services at www.azdhs.gov/prepardness/state-laboratory/newborn-screening/index.php for a listing of conditions and the Newborn Screening Panel. Metabolic formulas and medical foods are covered as specified in A.R.S. § 20-2327 and within the following limitations:
 - a. The Contractor and FFS Providers are responsible for the initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist,

- b. The Contractor and FFS Providers are responsible for all medically necessary laboratory tests and other services related to the provision of medical formulas/foods for members diagnosed with an inherited metabolic disorder,
- c. Metabolic formula or modified low protein foods shall be processed or formulated to be deficient in the nutrient(s) specific to the member’s metabolic condition; meet the member’s distinctive nutritional requirements; determined to be essential to sustain the member’s optimal growth within nationally recognized height/weight or BMI, and metabolic homeostasis; obtained under physician order; member’s medical and nutritional status shall be supervised by the member’s PCP, attending physician or appropriate specialist,
- d. Modified low protein foods shall be formulated to contain less than one gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein,
- e. Soy formula is covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until members are able to eat solid lactose-free foods,
- f. Foods that are available in the grocery store or health food store are not covered as a metabolic food, and
- g. Education and training regarding proper sanitation and temperatures to avoid contamination of foods which are blended or specially prepared for the member is required, if the member/Health Care Decision Maker (HCDM), Designated Representative elects to prepare the member’s food.

D. PROVIDER REQUIREMENTS

When requesting initial or ongoing PA for supplemental nutrition, providers shall provide the following:

1. A completed copy of Attachment A to support all the necessary requirements for Commercial Oral Nutritional Supplements as specified in this Policy.
2. Documentation of ongoing monitoring conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and any necessary adjustments.

Refer to the specific Contractor for managed care members or for FFS members, refer to AMPM Policy 820 for additional information on PA requirements.

For Body Mass Index (BMI) related information and tool(s), refer to the CDC website at <http://www.cdc.gov/healthyweight/assessing/bmi/>.