United Healthcare Medicare Advantage

Enteral and Parenteral Nutritional Therapy

Policy Number: MCS065.03
Approval Date: September 21, 2021

➲ Instructions for Use

Table of Contents | Page

Coverage Guidelines 1
Enteral Nutritional Therapy 1
Parenteral Nutritional Therapy 1
Policy History/Revision Information 1
Instructions for Use 2

Related Medicare Advantage Policy Guideline

- Enteral and Parenteral Nutritional Therapy (NCD 180.2)

Coverage Guidelines

Enteral and parenteral nutritional therapy is covered in accordance with Medicare coverage criteria.

Enteral Nutritional Therapy

Enteral nutrition therapy is covered when coverage criteria are met. Refer to the NCD for Enteral and Parenteral Nutritional Therapy (180.2). (Accessed September 9, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. Refer to the DME MAC LCD for Enteral Nutrition (L38955). (Accessed September 9, 2021)

For additional coding guidance, refer to the DME MAC Joint Article Enteral Nutrition - Correct Coding and Billing. (Accessed September 9, 2021)

Parenteral Nutritional Therapy

Parenteral nutritional therapy is covered when coverage criteria are met. Refer to the NCD for Enteral and Parenteral Nutritional Therapy (180.2). (Accessed September 9, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exists and compliance with these policies is required where applicable. Refer to the DME MAC LCD for Parenteral Nutrition (L38953). (Accessed September 9, 2021)

For correct coding and billing, refer to the Parenteral Nutrition – Correct Coding and Billing. (Accessed September 9, 2021)

For parenteral pumps, also refer to the Coverage Summary titled Infusion Pump Therapy.

Policy History/Revision Information

Date	Summary of Changes
09/21/2021	**Title Change** • Previously titled *Nutritional Therapy: Enteral and Parenteral Nutritional Therapy* **Coverage Guidelines** *Enteral Nutritional Therapy*

Proprietary Information of UnitedHealthcare. Copyright 2021 United HealthCare Services, Inc.

Date	Summary of Changes
	• Added language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; refer to the Durable Medical Equipment (DME) MAC LCD for *Enteral Nutrition (L38955)* • Removed reference link to the DME MAC Joint Article titled *Retirement of Enteral Nutrition LCD and Related Policy Article* for claims with dates of service on or after Nov. 12, 2020 *Parenteral Nutritional Therapy* • Added language to indicate LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the DME MAC LCD for *Parenteral Nutrition (L38953)* • Removed reference link to the DME MAC Joint Article titled *Retirement of Parenteral Nutrition LCD (L33798) and related Policy Article (A52515)* effective for claims with dates of service on or after Nov.12, 2020 Supporting Information • Archived previous policy version MCS065.02

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

CPT® is a registered trademark of the American Medical Association.

Proprietary Information of UnitedHealthcare. Copyright 2021 United HealthCare Services, Inc.