

PARENTERAL NUTRITION

Reference the [Look-Up Tool](#) to determine if a code requires a Service Authorization

DURABLE MEDICAL EQUIPMENT MANUAL

COVERAGE AND LIMITATION CRITERIA/POLICIES

EFFECTIVE: March 2007

REVISED: December 2025

PARENTERAL NUTRITION

Indications and limitations of coverage and medical appropriateness:

Coverage allowed if **ALL** the following conditions are present:

- Considered reasonable and necessary for a member with permanent or severe pathology of the digestive tract, which does not allow absorption of sufficient nutrients to maintain weight and strength.
- Consists of at least 90% of the patient's daily nutritional intake.

If a pump is required to deliver the nutritional supplement, reimbursement will be provided for the simplest model that meets the member's medical needs, as documented by the medical record. Only one pump will be covered at any one time. Limited to one every five years.

If all requirements are met, medically necessary nutrients, administration supplies, and equipment are covered.

The ordering physician/practitioner must have seen the member within 30 days prior to the initial certification. If the member cannot be seen, documentation must accompany the service authorization, stating the reason and how the member's enteral needs were evaluated.

No more than one month's supply of parenteral nutrients, equipment, or supplies is allowed for one month's prospective billing.

Documentation Requirements:

- Prescription from prescribing physician/practitioner.
- Physician/practitioner visit within 90 days of the service authorization start date that supports/addresses medical necessity.

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Non-covered:

- Requests for additional pumps will be denied as not medically necessary/ no exceptions.
- Special parenteral formulas (B5000-B5200) are non-covered/ no exceptions.

Date Revised	Revisions
June 2017	Reviewed and reformatted.
March 10, 2022	Reviewed and reformatted.
November 17, 2023	Reviewed and reformatted. Removed CMN required. Documentation Required section bullet three CMN deleted. Bullet two added Physician/practitioner visit within 90 days of the service authorization start date that supports/addresses medical necessity. Deleted Physician/practitioner’s documentation needs to address medical necessity.
December 18, 2025	Reviewed and reformatted. Replaced “Service Authorization” and “CMN” verbiage with “Reference the Look-Up Tool to determine if a code requires a Service Authorization”.