

**Medical Coverage Policy**

Policy Number – MP21-008E

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## Medically necessary foods

**Definition**

Medically necessary foods consist of specifically formulated and processed products (as opposed to a naturally occurring foodstuff used in its natural state) intended for the partial or exclusive feeding of an individual by means of oral intake, enteral feeding by tube, parenteral feeding by IV, or intraperitoneal administration.

**Policy statement**

*Disclaimer: This policy is applicable to TRICARE Prime and Select beneficiaries and may not apply to Active Duty Service Members (ADSM) under Supplemental Health Care Program (SHCP) or TRICARE Prime Remote (TPR) in accordance with TRICARE Operations Manual (TOM) Chapter 17, Section 3. Please review TOM Chapter 17, Section 3, Paragraph 2.0 onwards, regarding SHCP coverage and any TRICARE-specific exclusions included in this coverage policy to accurately determine the benefit for ADSMs.*

Medically necessary foods may be considered reasonable and necessary if one of the following conditions are met:

- I. Confirmed diagnosis of inborn errors of metabolism
- II. Full or partial non-function or disease of the structures that normally permit food to enter the small bowel
- III. Pathologies that impair digestion and/or absorption of an oral diet from the alimentary canal
- IV. A neurological or physiological condition

**Limitations of coverage**

- I. Beneficiary must be under active and ongoing medical supervision including instructions on the use of the food
- II. Medically necessary foods are used only under medical supervision, which may include in a home setting
- III. Outpatient services and supplies for [ketogenic](#) foods are only covered for the treatment of seizures that are refractory to anti-seizure medication
- IV. Inpatient [ketogenic](#) diet is covered only when it is part of a medically necessary inpatient admission for epilepsy
- V. Low protein modified foods ([LPMFs](#)) are covered only for beneficiaries with diagnosis-confirmed inborn errors of metabolism.
- VI. [Exclusions](#) as described in TRICARE Policy Manual Chapter 8, Section 7.2

**TRICARE Policy Manual (TPM) Chapter 8, Section 7.2****3.0 POLICY**

**3.1** Medically necessary food and medical equipment and supplies necessary to administer such food are covered by TRICARE when prescribed for dietary management of a covered disease or condition. Medically necessary food includes specialized formulas, a Low Protein Modified Food (LPMF) product or an amino acid preparation product. Medically necessary food and medical equipment and supplies may be covered when it is:

**3.1.1** Furnished pursuant to the prescription of a TRICARE authorized individual professional provider as described in [32 CFR 199.6](#) (e.g., physician, certified Nurse Practitioner (NP), or a certified Physician Assistant (PA), etc.) acting within the provider's scope of license/certificate of practice for the dietary management of a covered disease or condition as listed in [paragraph 3.2](#) ; and

**3.1.2** A specifically formulated and processed product (as opposed to a naturally occurring foodstuff used in its natural state) for the partial or exclusive feeding of an individual by means of oral intake, or enteral feeding by tube, or parenteral feeding by IV, or intraperitoneal administration; and

**3.1.3** Intended for the dietary management of an individual who, because of therapeutic or chronic medical needs, has limited or impaired capacity to ingest, digest, absorb, or metabolize ordinary foodstuffs or certain nutrients, or who has other special medically determined nutrient requirements, the dietary management of which cannot be achieved by the modification of the normal diet alone; and

**3.1.4** Intended to be used under medical supervision, which may include in a home setting; and

**3.1.5** Intended only for an individual receiving active and ongoing medical supervision under which the individual requires medical care on a recurring basis for, among other things, instructions on the use of the food.

**3.2** Covered disease or conditions include:

- Inborn Errors of Metabolism (IEM);
- Medical conditions of malabsorption;
- Pathologies of the alimentary tract or the gastrointestinal tract; and,
- A neurological or physiological condition.

**3.4 Specialized Formulas**

**3.4.1** Specialized formulas, to include amino acid based formulas, when covered as medically necessary food under [paragraph 3.1](#) , are listed in the "Enteral Nutrition Product Classification List." The list at: <https://www.health.mil/rates> .

**3.4.2** Specialized formulas included on the Enteral Nutrition Product Classification List are covered for enteral and oral consumption.

**3.5 Low Protein Modified Foods (LPMFs)**

**3.5.1** LPMFs, when covered as medically necessary foods under [paragraph 3.1](#), are those food products that have been modified to be low in protein for use by individuals who have been diagnosed with IEM (e.g., phenylketonuria (PKU), or maple syrup urine disease), and are not typically readily available in grocery stores. LPMFs are primary to the management of IEM, as they help those diagnosed with the condition, avoid organ damage, grow properly, and maintain or improve health status. LPMFs may be covered pursuant to a prescription, when medically necessary and appropriate for the treatment of IEM.

### **3.6 Ketogenic Diet**

**3.6.1** Inpatient ketogenic diet is covered when it is part of a medically necessary inpatient admission for epilepsy. Services and supplies will be reimbursed under the Diagnosis Related Group (DRG) payment methodology.

**3.6.2** Outpatient services and supplies for ketogenic diet are covered for the treatment of seizures that are refractory to anti-seizure medication. Covered supplies are included on the list maintained by Noridian Administrative Services and can be found at: <https://www.health.mil/rates>

## **5.0 EXCLUSIONS**

TRICARE covered medically necessary food and vitamins do not include:

**5.1** Food taken as part of an overall diet designed to reduce the risk of a disease or medical condition, or as weight-loss products, even if the food is recommended by a physician or other health care professional.

**5.2** Food marketed as gluten-free for the management of celiac disease or non-celiac gluten sensitivity.

**5.3** Food marketed for the management of diabetes.

**5.4** Vitamins or mineral preparations, except as provided in [paragraph 3.3](#).

**5.5** Nutritional supplements administered in the absence of a covered disease or a medical condition that is listed in [paragraph 3.2](#).

**5.6** Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

**5.7** Items used primarily for convenience or for features which exceed that which is medically necessary (for example, prepackaged, liquid vs. powder, etc.).

**5.8** Nutritional products that are marketed for use for individuals without medical conditions.

**5.9** Naturally occurring foodstuff used in its natural state, to include those that are naturally low in protein. Excluded items are those not intended to be used under the direction of a physician for the dietary treatment of an inborn error of metabolism.

**5.10** Healthcare Common Procedure Coding System (HCPCS) code B4104 is an enteral formula additive. The enteral formula codes include all nutrient components, including vitamins, mineral and fiber. As a result B4104 is not separately payable.

5.11 Specialized formulas, except those covered in [paragraph 3.4](#).

#### References

1. TPM Chapter 8, Section 7.2 [TRICARE Manuals - Display Chap 8 Sect 7.2 \(Change 123, Feb 15, 2024\) \(health.mil\)](#)
2. Centers for Medicare and Medicaid Services. National Coverage Determination 180.2 Enteral and Parenteral Nutritional Therapy. Effective Date 07/11/1984
3. MCG Health. Gastrostomy Tube, Percutaneous Endoscopic (PEG). Ambulatory Care. 27th edition. ACG: A-0442 (AC). Last reviewed: 09/21/2023

Approved by:



Joseph F. McKeon, MD, MPH

Chief Medical Officer

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