Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Oral Formula: Rhode Island Products

Effective: August 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial product

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

This guideline is for the review of formulas given or taken by mouth. It does not apply to those formulas given via a tube

Clinical Guideline Coverage Criteria

The Plan's coverage of oral formula for Rhode Island products is limited to the following diagnoses. The member will be able to order one month's supply at a time.

1. Formulas prescribed for the treatment of inborn errors of metabolism as mandated by Rhode Island law:
    a. Tyrosinemia
    b. Hpomocytinuria
    c. Maple syrup urine disease
    d. Propionic acidemia
    e. Methylmalonic acidemia
    f. Urea cycle disorders
    g. Phenylketnuria (PKU)
    h. Other organic acidmias
2. Enteral formuals prescribed for the medical treatment of malabsorption resulting from one of the following conditions as mandated by Rhode Island law:
    a. Crohn's disease
    b. Ulcerative colitis
    c. Gastrointestinal dysmotility
    d. Gastroesophageal reflux (GERD)
    e. Chronic intestinal pseudo-obstruction
    f. Inherited diseases of amino acids and organic acids

Note: For Rhode Island products, The Plan does not cover formula for the treatment of any diagnosis not listed in bullets 1 and 2 of the above coverage guidelines. All members with a Rhode Island product must obtain the formula from a medical supply vendor

Limitations

The Plan may not authorize oral formula for any of the following:

1. Standard infant milk or soy formulas
2. Baby food or other regular food products including those that are blended and use in tube feedings
3. Formula or food products used for dieting, or a weight-loss program
4. Banked breast milk
5. Food for a ketogenic diet when dietary needs can be met with regular, store-bought food
6. Dietary or food supplements
7. Food thickeners, high protein powders and mixes
8. Lactose free foods or products that aid in lactose digestion
9. Gluten-free products
10. Baby foods
11. Oral vitamins and minerals
12. Medical foods (e.g., Folttx, Mentax, Cerefolin, probiotics such as VSL #3) including FDA approved medical foods obtained via prescription
13. Soy formula in children able to tolerate soy-based foods.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may

Code	Description
	include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

References:

1. State of Rhode Island. Enteral Nutrition Products. H7441, Section 40-6-3, 12. July 5, 2008. webserver.rilin.state.ri.us/PublicLaws/law08/law08253.htm.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC. Link to Attachment B “Additional Protein Hydrolysate and Premature Infant Formulas” removed. Applicable HCPCS codes added: B4149-B4160

Subsequent endorsement date(s) and changes made:

- December 21, 2021: by Medical Policy Approval Committee (MPAC), renewed without changes
- April 7, 2022: Template updated
- December 1, 2022: Reviewed by MPAC, renewed without changes
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- November 21, 2024: Reviewed by MPAC; prior authorization requirements clarified, effective January 1, 2025
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- June 17, 2026: Reviewed by MPAC for annual review, renewed without changes effective August 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.