Preferred IPA of California
Be a Preferred Provider

JANUARY 2018

PROVIDER BULLETIN

FORMULA REFERRAL PROCESS

Preferred IPA is committed to ensuring timely access to care for our patients. The referral process is faster for your patients when a referral is submitted with the required information for processing. The purpose of this bulletin is to share referral requirements for these specific services to ensure your patients receive approved services as quickly as possible.

Please review this important bulletin for formula referral submission requirements.

Each formal referral request must include:

- Current physician order for the formula & physician signature on the referral
- Diagnosis - ICD10 code(s)
- Patient height, weight and BMI
- Route of administration (Bolus or Gravity Feeds, oral, pump)
- Formula type
- Dosage
- Daily caloric requirements
- Estimated duration of need for the enteral nutrition product and/or nutrition care plan
- Biochemical, clinical and/or dietary indicators related to the request for product
- Growth Chart for patients aged 0-21
- Relevant records/visit notes supporting the request

If this information is not included with the referral request, the attached Formula Questionnaire will be sent out with a deferral letter to the referring provider.

Medical Management & Claims Department Contact Numbers:
Phone: (800) 874-2091
UM Fax: (800) 874-2093

? Questions? Contact Provider Relations at 818-265-0800 ?

FORMULA QUESTIONNAIRE

<PATIENT.NAME>
MEMBER DOB: <PATIENT.DOB>

REFERRAL #: <AUTH.ID>
FAX TO 1-800-874-2093

Medical diagnosis related to the product requested (ICD 10):
1. _____ 2. _____

Patient Information:

Age	Height (length)	Weight	Body Mass Index BMI

Route of administration/ Daily caloric requirements

Administration Type	Formula Type	Daily Dose
☐ Oral		
☐ Pump		
☐ Bolus or Gravity Feeds		

Estimated duration of need for the enteral nutrition product and/or nutrition care plan.
☐ 3 mo ☐ 6 mo ☐ 9 mo ☐ 12 mo ☐ lifelong

Biochemical, clinical and/or dietary indicators related to the request for product:
_____
_____

PLEASE ATTACH REQUIRED DOCUMENTATION BASED ON YOUR REFERRAL TYPE:

Oral Formula (Ages 0-21) with diagnosis of: Failure to Thrive, Underweight, Milk Allergy, etc.
☐ MD order (required every 3 months to support continued authorization)
☐ Current Growth Chart included showing member <5th Percentile
***New growth chart required every 3 months to support continued authorization unless diagnosis is a milk allergy, then growth chart required every 6 months to support continued authorization.*

Formula with Pump, Bolus or Gravity Feeds
☐ MD order (required every 3 months to support continued authorization)
☐ Records showing member is still nutritionally at risk for significant weight loss
☐ Records showing if member is being transitioned to oral feeds and amount of oral intake

Lifelong Patient w/Chronic Medical Diagnosis Formula with Pump, Bolus or Gravity Feeds
☐ Adult Change to Formula Type and Quantities ☐ Yes ☐ No
☐ Pediatrics Change to Formula Type and Quantities ☐ Yes ☐ No
****If yes to changes, must attach New MD Order. For Pediatrics, must also attach new growth chart.**

Physician Signature: _____ Date: _____

CLINICAL CRITERIA FOR FORMULA REFERRAL*

***Excerpt from Medi-Cal.ca.gov**

- **CRITERIA: (Age 0-21) - Oral Formula OR Formula with Pump, Bolus or Gravity Feeds**
  - Documented chronic medical diagnosis (including PKU) and patient unable to meet their nutritional needs with dietary adjustment of regular or altered-consistency (soft or pureed) foods. There must be clinical indicators identified and documented that support the beneficiary is nutritionally at risk.
  - Documented clinical signs and symptoms of stunting, wasting or underweight with patient at nutritional risk with one of the following three scenarios:
    - Standard and modified growth charts should be used to document nutritional need and patient deficiency.
    - Severe swallowing or chewing difficulty due to one of the following: cancer in the mouth, throat or esophagus; Injury, trauma, surgery or radiation therapy involving the head or neck; chronic neurological disorders; Severe craniofacial anomalies.
    - Transitioning from parenteral or enteral tube feeding to an oral diet

- **CRITERIA (Age 21 and older) - Oral Formula OR Formula with Pump, Bolus or Gravity Feeds**
  - Documented chronic medical diagnosis and patient unable to meet their nutritional needs with dietary adjustment of regular or altered-consistency (soft or pureed) foods. There must be clinical indicators identified and documented that support the beneficiary is nutritionally at risk.
  - Medical condition and adequate nutrition is not possible with dietary adjustment of regular or altered-consistency (soft or pureed) foods. There must be documentation beneficiary is nutritionally at risk with one of the following anthropometric measures:
    - involuntary loss of 10 percent or more of usual body weight within six months;
    - involuntary loss of 7.5 percent or more of usual body weight within three months;
    - Involuntary loss of 5 percent or more of usual body weight in one month;
    - body mass index less than 18.5 kg/m2.

NOT COVERED by Medi-Cal:

The following nutrition products are not covered by Medi-Cal: Regular food, including solid, semi-solid and pureed foods; Common household items; Regular infant formula as defined in the Federal Food, Drug and Cosmetic Act (FD&C Act); Shakes, cereals, thickened products, puddings, bars, gels and other non-liquid products; Thickeners; Products for assistance with weight loss; Vitamin and/or mineral supplements, except for pregnancy and birth up to 5 years of age (Refer to the appropriate contract drugs list section in this manual for more information); Enteral nutrition products used orally as a convenient alternative to preparing and/or consuming regular solid or pureed foods.

Not Separately Reimbursed:

(1) Enteral nutrition products provided to inpatients receiving inpatient hospital services are included in the hospital's reimbursement made under the CCR, Title 22, section 51536. These products are not separately reimbursable.
(2) Enteral nutrition products provided to inpatients receiving Nursing Facility Level A services or Nursing Facility Level B services are not separately reimbursable.
(3) Enteral nutrition products and infusion nutrients that are provided to beneficiaries during chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units, or for use during home dialysis are not separately reimbursable. Pharmacies that furnish enteral or infusion nutrition products to hemodialysis centers, community hemodialysis units or to beneficiaries for home dialysis should bill the dialysis provider directly.