Clinical Policy: Immobilized Lipase Cartriges (Relizorb)

Reference Number: NM.CP.MP.504
Last Review Date: 02/24
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Immobilized lipase cartridges (Relizorb) are lipase-containg devices used to hydrolyze the fats contained in enteral feedings.

Immobilzed lipase cartridges (Relizorb) contain lipase which is bound to microbead carier molecules contained within the cartridge. When enteral formula passes through the cartridge, the lipase hydrolyzes the triglycerides contained within the formula. This increases the absorption of fats in the digestive tract. The use of immobilized lipase cartriges is indicated in members with pancreatic insufficiency who receive enteral nutrition.

Policy/Criteria

Providers must submit documentation such as office visit notes, lab results or other clinical information to support the request for immobilized lipase cartriges.

I. It is the policy of Western Sky Community Care that immobilized lipase cartriges are medical necessary when the following criteria are met:
   A. The member has exocrine pancreatic insufficiency and is five years of age or older.
   B. The member receives enteral feedings via pump.

II. If criteria are met, a maximum of 62 cartridges/month can be approved.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CLINICAL POLICY
RELiZORB®

HCPCS ®* Codes	Description
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		06/23/22
Annual review, no changes	02/06/2023	03/15/2023
Annual review, no changes	02/15/2024	02/21/2024

References

1. Clinical trials.gov. Safety, Tolerability and Fat Absorption Using Enteral Feeding In-line Enzyme Cartridge (Relizorb) , ClinicalTrials.gov Identifier: NCT02598128. Last updated: June 2016 (Final data collection date for primary outcome measure)

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.