



***PMB definition guideline: Medical Nutrition Therapy for PMB conditions (adults
and paediatrics)
Version 1***

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Disclaimer:

The medical nutrition benefit definition guideline was developed for the majority of standard patients and is aligned with best practice. These benefits may not be sufficient for outlier patients. Therefore, regulation 15(h) may be applied for patients who are inadequately managed by the stated benefits. The diagnostic categories included in this PMB Guideline reference all PMB conditions included in the National Department of Health 2020 draft National Clinical Nutrition Guide.

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ABBREVIATIONS

BMI	-	Body Mass Index
CMS	-	Council for Medical Schemes
COPD	-	Chronic Obstructive Pulmonary Disease
DKA	-	Diabetic ketoacidosis
DRM	-	Disease-related Malnutrition
DTPs	-	Diagnosis Treatment Pairs
EN	-	Enteral Nutrition
FSMP	-	Food for Special Medical Purposes
MAM	-	Moderate acute malnutrition
MNT	-	Medical Nutrition Therapy
MUAC	-	Mid upper arm circumference
ONS	-	Oral Nutrition Supplementation
PEG/PEJ	-	Percutaneous Endoscopic Jejunostomy/Percutaneous Endoscopic Gastronomy
PEM	-	Protein Energy Malnutrition
PMB	-	Prescribed Minimum Benefit
PN	-	Parenteral Nutrition
SAM	-	Severe acute malnutrition
WFA	-	Weight-for-age
WFH	-	Weight-for-height
WFL	-	Weight-for-length

DEFINITIONS

Medical Nutrition Therapy (MNT)

A therapeutic approach to treating medical conditions and their associated symptoms via the use of a specifically tailored nutritional intervention devised and monitored by a registered dietitian, and based upon the patient's diagnosis, medical record, treatment plan, clinical course, physical examination, symptoms, and full nutritional assessment (adapted from Skipper, 2009).

Protein-energy malnutrition (PEM)

It is defined as an imbalance between the supply of protein and energy and the body's demand for them to ensure optimal growth and function. It can be classified as mild, moderate or severe and can be primary the cause – as a result of nutrient deficits, or secondary - as a result of disease, or medical treatments (MSD Manual)

Disease-related malnutrition (DRM)

A particular malnutrition syndrome, which results from the physiological inflammatory and/or anorexigenic or other mechanisms of illness or disease and presented as a loss of body mass/low body mass index (i.e. evidence of Protein-Energy Malnutrition) and/or compromised nutritional intake with functional impairment (derived from Jensen, 2013).

Food for Special Medical Purposes (FSMP)

The category of foods for special dietary uses which are specially processed or formulated and presented for the dietary management of patients and may be used only under the supervision of a registered dietitian.; They are intended for the exclusive or partial feeding of patients with limited or impaired capacity to take, digest, absorb or metabolise ordinary foodstuffs or certain nutrients contained therein, or who have other medically determined nutrient requirements, whose dietary management cannot be achieved only by modification of the normal diet, by other foods for special dietary uses, or by a combination of the two.

1. INTRODUCTION

- 1.1. The legislation governing the provision of the Prescribed Minimum Benefits (PMBs) is contained in the Regulations enacted under the Medical Schemes Act, 131 of 1998 (the Act). Regarding some of the Diagnosis Treatment Pairs (DTPs), medical scheme beneficiaries find it difficult to be fully aware of their entitlements in advance. In addition, medical schemes interpret these benefits differently, resulting in a lack of uniformity of benefit entitlements.
- 1.2. The benefit definition project is undertaken by the Council for Medical Schemes (CMS) to define the PMB package and guide the interpretation of the PMB provisions by relevant stakeholders.

2. SCOPE AND PURPOSE

- 2.1. This guideline is intended as a recommendation for medical nutrition therapy (MNT) benefits for a wide variety of PMB conditions for which MNT as PMB level of care has been previously undefined, including both adults and paediatrics. This will align the PMBs for nutrition support to the 2020 National Department of Health Draft *National Clinical Nutrition Guide*, which has been developed in preparation for the universal health coverage implementation process.
- 2.2. The purpose of this guideline is to provide a detailed clarification in respect of benefits and entitlements to members and beneficiaries of medical schemes as regards specified MNT benefits for multiple core PMB conditions for which MNT is central to disease treatment and/or management, in any type of in-patient clinical setting as well as as part of out-patient, community, residential or home care.

3. MEDICAL NUTRITION THERAPY IN TREATMENT AND MANAGEMENT OF DISEASE

- 3.1. MNT is a purposeful, evidence-based therapeutic intervention forming an integral part of medical care intended to treat or manage an acute or chronic medical condition (Sucher, 2020). In some clinical scenarios, MNT is essential treatment of the disease, such as in inborn errors of metabolism or the various forms of malnutrition. In other conditions, MNT is a therapeutic management tool, which provides adjunctive health benefits in the form of enhanced clinical, metabolic, biochemical, or anthropometric health parameters with the consequences of improved disease status, improved response to therapies, reduced disease progression or other measurably improved clinical outcomes. Examples are chronic diseases of lifestyle.
- 3.2. MNT is also a clinically appropriate intervention where treatment of a disease condition or acute illness by means of pharmaceutical, surgical, or other medical interventions creates or worsens nutritional deficits, compromises nutritional status, impedes nutrient absorption, assimilation, or metabolism, produces symptoms or side-effects which lead to reduced nutrient intake, or where nutritional losses occur. Examples are cancers, gastrointestinal diseases or in the post-operative setting.
- 3.3. MNT is associated with various measurable clinical benefits including maintenance and restoration of nutritional status, management of symptoms of disease and treatment, improved metabolic control, reduced dependency on chronic drugs or reduced chronic drug dosing requirements, reversal of health risk factors, reduced or slowed chronic disease progression, treatment of disease processes, prevention of clinical complications, improved

functional capacity and enhanced quality of life (MNI Report, 2012).

- 3.4. Apart from being clinically beneficial, MNT has been demonstrated in international studies from various countries to be both cost-effective and cost-saving. Cost-savings occur mainly because of shorter ICU and hospital stays, reduced healthcare resource utilisation and reduction in clinical complications, with the overall effect of reduced global cost of care. The potential for MNT to reduce overall health care spend is not well recognised. Malnourished patients cost on average 2-3 times more to treat than those without malnutrition, while net savings generated from clinically rational utilisation of MNT have been shown to be around 10% (Freijer et al 2013; Freijer, et al, 2014, Schuetz et al, 2020). Given the constraints on healthcare resources in South Africa, CMS recommends that schemes collect, analyse, and share their findings to support future MNT policy as a cost-saving interventional strategy in disease prevention and management.
- 3.5. There is no disease or illness that is benefitted or improved by an underlying, concurrent, or progressive malnourished state. Apart from the underlying malnutrition that may occur as a result of hunger or socioeconomic conditions, many diseases and illnesses are commonly associated with a specific malnutrition syndrome, known as disease-related malnutrition (DRM) (Jensen et al, 2013). DRM occurs when the physiological inflammatory and/or anorexic state induced by disease coexists or coincides with signs, symptoms, and treatment modalities that negatively impact nutritional intake and parameters, leading to compromised nutritional status and unfavourable body composition and various types of poor clinical outcomes, including mortality.
- 3.6. Management of DRM by means of MNT is crucial since malnourished patients progress more rapidly in their clinical course, experience more complex disease progression, tolerate and respond to medical treatment interventions more poorly, develop more clinical complications, require more frequent hospitalisation and have longer hospital stays. Therefore, their clinical care is both more complicated and more expensive than that of their well-nourished counterparts (Arends, et al, 2017a; Freijer et al, 2013).
- 3.7. The spectrum of MNT ranges from oral diet strategies (diet and food modifications of various kinds, including nutrient supplements) combined with skilled nutritional counseling/education/advice, feeding environment adaptation, dietary planning, coordination of overall nutritional care, use of oral nutrition supplements, enteral tube-feeding of various kinds, and parenteral nutrition. Any or all of these approaches can be used in combination or in sequence to achieve the stated nutritional goals and depending on clinical circumstances and factors as well as ethical considerations. See Figure 1.

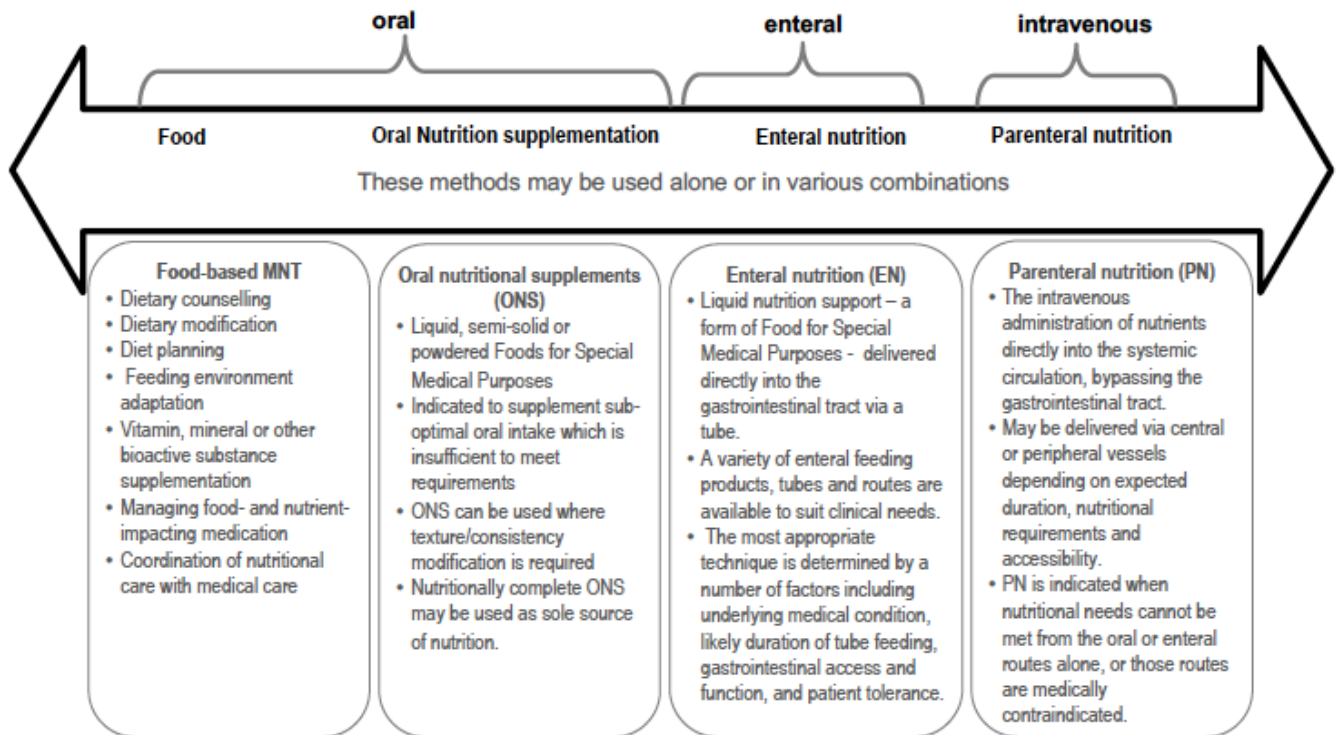


Figure 1. The spectrum of routes of MNT

4. THE ROLE OF THE PROFESSIONAL DIETITIAN IN DELIVERING MEDICAL NUTRITION THERAPY

- 4.1. MNT is a nutrition-based intervention within the wider regulated scope of practice of the registered dietitian. While some aspects of nutrition screening and monitoring can be incorporated into the workflow of other health professionals, the registered dietitian is the South African health professional regulated to provide executive, scientifically justified therapeutic nutrition interventions and counselling services as part of medical treatment of patients.
- 4.2. Nutrition screening is the basic evaluation of nutritional risk and malnutrition. According to international practice standards, nutrition screening should be incorporated into every level of healthcare where patients or potential patients interact with health-related point of care (Cederholm and Jensen, 2017). Nutrition screening can be done by any suitably trained health professional not limited to a registered dietitian and can be used as a basis for referrals of patients to dietetic care.
- 4.3. The dietitian provides MNT according to a Nutrition Care Process framework (Lacey and Pritchett, 2003; Swan et al, 2017), which is intended to provide consistent care structure and quality. The Nutrition Care Process is an integrated cycle of steps incorporating:
 - 4.3.1. **Nutrition Assessment and/or Re-assessment** based upon appropriate anthropometric techniques, biochemical data, clinical data, socio-economic information, and nutritional/dietary intake data
 - 4.3.2. **Nutrition Diagnosis** identifying and labelling nutritional problems and their causes or contributing factors

- 4.3.3. **Nutrition Intervention** including the determination of nutritional requirements, formulation of nutritional goals and implementing nutrition delivery. This may include training/counselling of caregivers or family members.
- 4.3.4. **Nutrition Monitoring and Evaluation** including the monitoring of progress, success, and outcomes against key indicators.
- 4.4. The clinically appropriate number of professional consultations with a registered dietitian for delivery of MNT depends on the diagnosis, clinical condition, and progress of the patient.
- 4.5. Dietitians may work within a multi-disciplinary team, as necessary, in order to deliver medical nutrition therapy within an integrated, co-operative and comprehensive overall medical plan.
- 4.6. Dietitians may be involved in Care Pathways at various points of care, upon referral at diagnosis. See Figure 2.
- 4.7. Dietitians are able to play an important role in cost containment and reducing pressure on in-patient facilities by delivering all aspects of MNT outside of an acute care in-patient clinical setting. It is important to recognise that an integrated care pathway for MNT delivery across the spectrum of healthcare services from hospital settings into sub-acute and community-based care facilities under dietetic supervision is clinically, ethically, practically, and economically feasible.

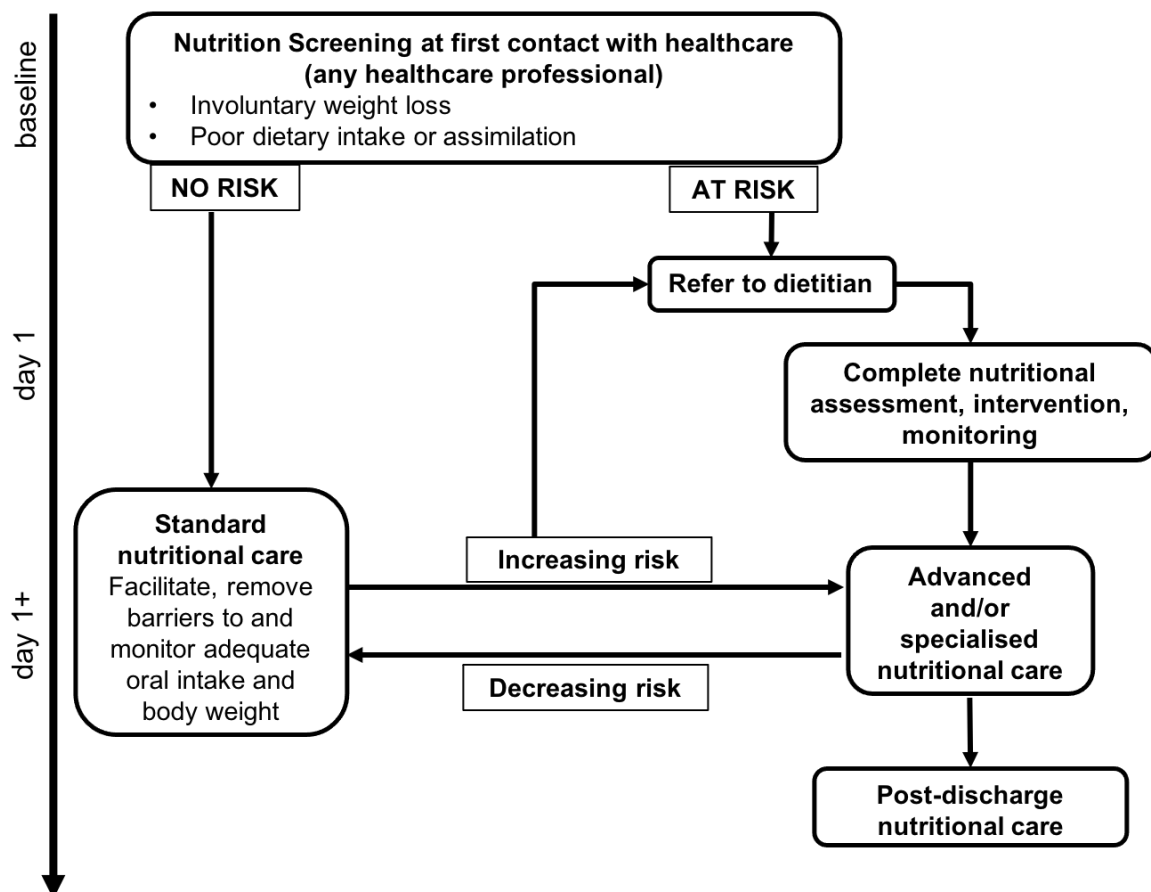


Figure 2. Care Pathways for dietitian referrals (adapted from Keller et al, 2015)

5. CRITERIA FOR MNT IN PMB CONDITIONS

For some illnesses and diseases, merely the diagnosis of one of the PMB conditions outlined in this guidance document automatically prompts the requirement for MNT upon referral from the treating provider, since nutrition support interventions are the means of treating or managing the diagnosed condition. PMB conditions which fall into this category are:

- Malnutrition falling under DTP 236K: ICD-10 E40-E46
- Life-threatening congenital abnormalities of carbohydrate, lipid, protein, and amino acid metabolism DTP 901K: all ICD-10s in this DTP category
- Inborn errors of liver metabolism falling under DTP 911G: E70.2, E70.9, E72.0, E72.2 – E72.5, E72.8, E72.9, E74.0, E74.4, E74.8, E74.9, E77.0, E77.1, E77.8, E78.6, E78.8, E78.9
- Anorexia Nervosa and Bulimia Nervosa DTP 908T: ICD-10 F50.0-F50.3

For the other PMB conditions contained in this guideline, the diagnosis should trigger an assessment for the requirement for MNT. Certain pre-defined global entry and exit criteria are universally applicable as triggers for MNT and dietetic care, and discharge from such nutritional care. These are outlined below. Other additional criteria relate only to specific diseases, diagnoses, or disease progression patterns. These are stated within the remainder of the document as each condition/diagnosis is discussed. Of special note is Chronic Diseases of Lifestyle (see Table 12), which should be actively managed according to protocols in line with international guidelines for the various metabolic and weight-related risk factors of those diseases. The criteria described in this section and any additional disease-specific criteria outlined in section 7 of this document are not mutually exclusive. Therefore, section 5 of this document should be read in conjunction with section 7 below.

5.1. Entry criteria

Universal entry criteria for MNT for PMB conditions are:

- Unintentional weight loss of $\geq 5\%$ usual body weight in an adult regardless of the time (see Table 2 below).
- The presence of Protein-Energy Malnutrition (PEM) of any grade measured by body mass index (BMI) in an adult (see Table 3 below);
- The presence of age-appropriate weight-for-height/length Z-score of below -2 standard deviations and/or height/length-for-age of below -2 standard deviations and/or mid upper arm circumference of below age-related threshold and/or BMI-for-age below -2 standard deviations in a baby or child (WHO Guideline, 2017, see Table 4 below);
- The presence of weight loss or a sustained drop/downward crossing of two percentile lines on growth charts in a baby or child (see Table 4 below);
- The presence of BMI-for-age of $>98^{\text{th}}$ percentile or more than +3 standard deviations in a child (see Table 4);
- The presence of premature birth (<37 weeks), low birth weight ($<2500\text{g}$), very low birth weight ($<1500\text{g}$) or extremely low birth weight ($<1000\text{g}$) in an infant;

- The presence of clinical conditions or symptoms negatively impacting nutrient intake or assimilation and/or which increase nutritional losses;
- The diagnosis of any condition for which the clinically appropriate primary treatment/management or main adjunctive treatment/management is MNT in any form.

Note: assessment of nutritional risk and growth parameters according to growth charts used for babies and children should utilise the correctly adapted growth charts and adjusted/corrected parameters for premature babies, cerebral palsy, Down syndrome etc as applicable.

Table 1. Weight loss history (Mahan, Escott-Stump & Raymond, 2012)

Classification of severity of malnutrition and malnutrition risk by percentage weight change		
Duration	Significant weight loss	Severe weight loss
1 months	5%	> 5%
3 months	7.5%	> 7.5%
6 months	10%	> 10%

Table 2: Classification of Protein-Energy Malnutrition (PEM) in adults (Lee & Nieman, 2003).

Body Mass Index (BMI) = $\frac{\text{Body weight (kg)}}{\text{height (m)}^2}$	
BMI (kg/m ²)	PEM Severity
> 18.5	Normal
17.0 – 18.4	Mild
16.0 – 16.9	Moderate
<16	Severe

Table 3: Classification of malnutrition in infants and children

Criteria		Classification						
WFH/L	6-59 months	< -3 standard deviations	Between -2 and -3 standard deviations	Losing weight Flattening growth curve	> -2 standard deviations	Between +2 and +3 standards deviations	> +3 standard deviations	
	BMI/Age							5-18 years
MUAC	6-59 months	≤ 11.5 cm	11.5-12.5 cm					
	5-9 years	<13.5 cm	13.5-14.5 cm					
	10-14 years	<16 cm	16-18.5 cm					
	15-18 years	<21 cm	21-23 cm					
Visible wasting	Yes	Yes/No	No	Not applicable				
Bilateral pitting oedema	No	Yes	No*					
Medical complications	No	Yes	No/Yes					
Appetite/able to breastfeed	Good	Poor	Good/Poor					
Well and alert	Yes	No	Yes/No					
Diagnosis		SAM without complications	SAM with complications	MAM	Poor growth	Normal	Overweight	Obese

5.2. Criteria for routes of MNT delivery

Patients requiring MNT may benefit from one or more routes of MNT delivery in combination or in sequence while transitioning from one to another. See Figure 3.

5.2.1. Food-based MNT

This MNT modality is suitable for patients who are completely able to consume their nutritional and fluid requirements through the intake of ordinary food, but who require therapeutic modification of the diet content, composition, type or pattern under dietetic supervision and expertise.

5.2.2. Oral Nutrition Supplementation (ONS)

ONS is intended to supplement ordinary oral diet under any/all the following conditions:

- Patients meet universal or disease-specific entry criteria for MNT.
- Patients cannot achieve or maintain an ordinary oral intake meeting at least 80% of their nutritional requirements via ordinary food alone;
- Patients require significant texture or consistency modification of oral intake;
- Patients require FSMP products with specialised compositional features that cannot be replicated using ordinary food in the clinical judgement of the dietitian (e.g. hydrolysed or amino-acid based formulas);
- Patients have no medical contraindications to oral intake and/or oral intake of liquid foodstuffs

5.2.3. Enteral nutrition (EN)

EN is indicated under any/all of the following conditions:

- Patients meet universal or disease-specific entry criteria for MNT;
- Patients are unable to meet at least 80% of their nutritional requirements orally due to increased requirements, inadequate oral intake or symptoms (e.g., dysphagia, oral mucositis);
- Oral intake is unsafe or mechanically/technically impossible (e.g. structural or mechanical head/facial/dental pathology; reduced state of consciousness; dysphagia with risk of pulmonary aspiration; obstruction of the oropharynx, or any part of the upper gastrointestinal tract; mechanical ventilation; tracheostomy etc);
- Where disordered sucking, swallowing or other oral feeding disorder occurs in paediatric patients;
- Patients require specialised FSMP products that cannot be replicated using an oral form of MNT as per the dietitian's clinical judgement, due to the nature of the diagnosis, symptoms or other clinical condition (e.g., short bowel syndrome, malabsorption syndromes, organ dysfunction; severe gastrointestinal intolerance);
- Patients have no medical contraindications to enteral feeding.

Enteral nutrition may be delivered via a nasogastric/nasojejunal, jejunostomy or PEG/PEJ tube depending on the expected duration of enteral feeding and optimal site of access. In medically stable patients, enteral nutrition outside of the hospital setting is feasible. Patients without other indications for in-patient care need not remain in hospital purely for the purposes of continued enteral feeding.

5.2.4. Parenteral Nutrition (PN)

PN is indicated under any/all of the following conditions:

- Patients meet universal or disease-specific entry criteria for MNT;
- When the gastrointestinal tract is not functional or accessible (e.g., paralytic/mechanical ileus, bowel obstruction, ischaemia or perforation);
- When enteral intake is contraindicated or likely to exacerbate limited gastrointestinal functional capacity with unfavourable risk-benefit ratio (e.g. necrotizing enterocolitis, toxic megacolon, diffuse peritonitis, gastrointestinal bleeding);
- Patients are unable to meet at least 80% of their nutritional, fluid and electrolyte requirements enterally due to increased requirements, inadequate enteral intake or other symptoms driving enteral losses (e.g., high output fistula/stoma, intractable diarrhoea, high physiological stress);

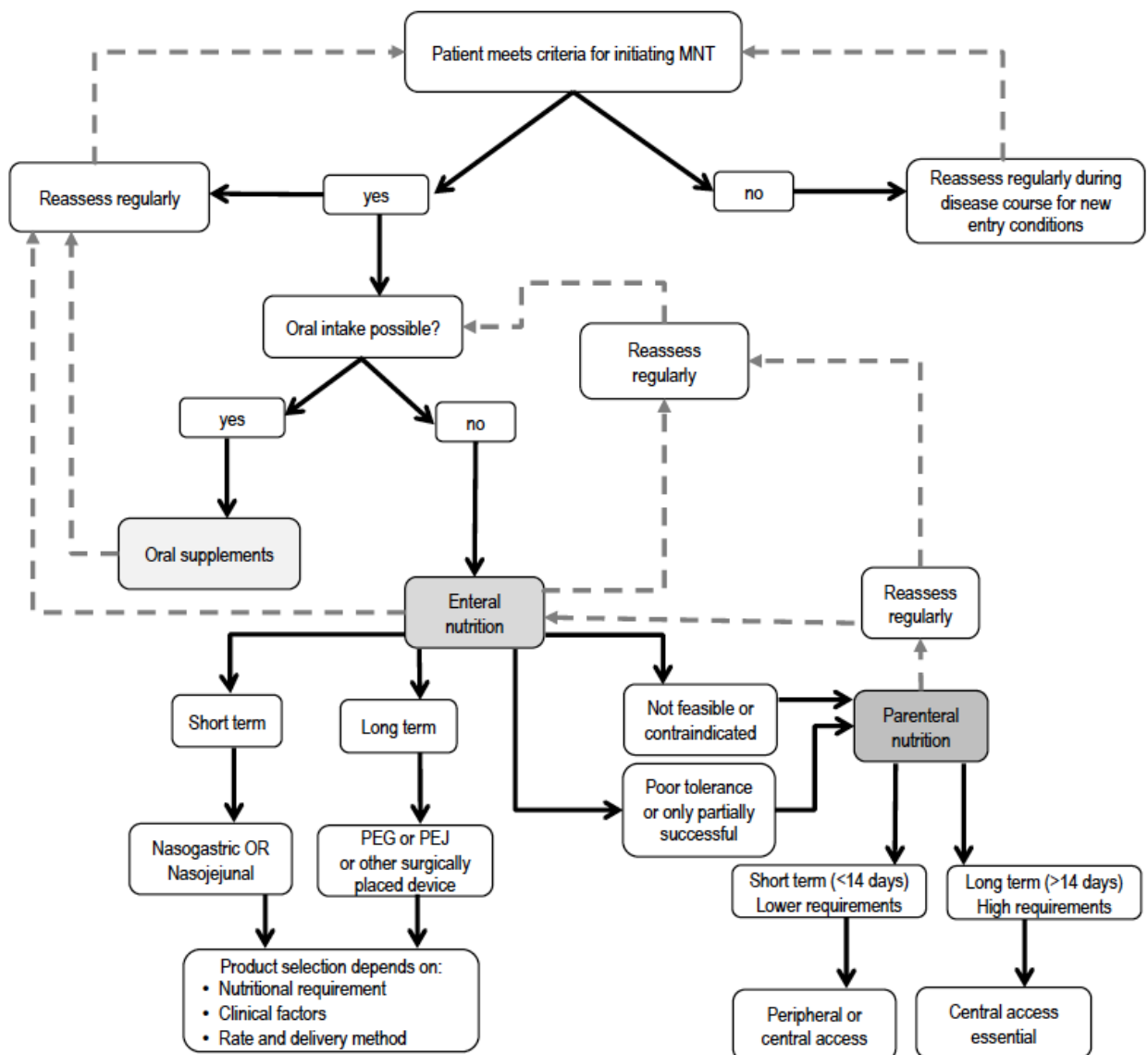
Parenteral nutrition may be delivered via a centrally or peripherally inserted vascular cannula depending on the expected duration of parenteral nutrition delivery, nutritional and fluid requirements and clinical setting.

Figure 3. Algorithm for MNT delivery (adapted from A.S.P.E.N. Clinical Guideline 2009)

5.3. Exit criteria

Patients may only be exited entirely from the MNT benefit when any of the following criteria are met:

- Applicable indicators of nutritional risk or malnutrition have normalised and remained normal without relapse OR have improved and stabilised to an adequate, clinically acceptable degree in the assessment of the dietitian AND the underlying condition/disease/circumstance which caused the nutritional compromise has resolved;
- In patients without malnutrition, when the underlying condition/disease which precipitated the nutritional risk or requirement for MNT has resolved;
- Symptoms or nutrition-impacting clinical problems which necessitated commencement of MNT have resolved, or improved to the point where MNT is no longer required in the judgement of the dietitian;



- Continued MNT is regarded as unethical, futile or non-beneficial/harmful in the consensus judgement of the multi-disciplinary team.

With due consideration to the above exit criteria, MNT modalities may require withdrawal in a stepwise or sequential fashion, as follows:

For patients on parenteral nutrition, parenteral formulations may be discontinued when both of the following criteria are met:

- Enteral and/or oral nutrition becomes feasible and safe due to resolution of the original requirement for parenteral nutrition AND enteral and/or oral nutrition is able to consistently provide at least 80% of nutritional requirements;
- Patients are able to maintain hydration and electrolyte status by enteral and/or oral means alone.

For patients on enteral tube-feeds, enteral feeding may be discontinued when any of the following criteria are met:

- Ability to eat an oral diet returns and where oral intake will successfully and safely provide at least 80% of nutritional requirement as evaluated by a dietitian;
- Symptoms or nutrition-impacting clinical conditions driving nutritional losses via the gastrointestinal tract are well controlled to the extent that they do not impact upon nutrient assimilation or nutritional status, allowing for progression to oral diet.

Note: Patients discontinuing enteral feeding may still require ONS.

For patients on ONS, ONS may be discontinued when the following criterion is met:

- Ability to eat ordinary oral diet is restored to the extent that intake provides nutritional requirement;

Note: There can be no exit from MNT for chronic diseases and permanent conditions for which MNT is a primary aspect of treatment or disease management. However, MNT modalities and frequency of consultations with the dietitian can be modified to a baseline maintenance level once clinical stability occurs and remains stable.

6. CHOICE OF FOOD FOR SPECIAL MEDICAL PURPOSES PRODUCT

Multiple Food for Special Medical Purposes (FSMP) products are available (see Figure 4) for clinical use both in and out of hospital and the appropriate choice of product regarded as clinically appropriate should be determined by the dietitian, with reference to various clinical factors. For use in all levels of clinical care from in-patient facilities, sub-acute care, residential care facilities and community- and home-based, FSMP products include unscheduled commercial liquid, semi-liquid and powdered products regulated for use under medical supervision. FSMP products are widely available in the state sector according to the transversal contract (<http://www.treasury.gov.za/divisions/ocpo/ostb/contracts/RT9-2020.zip>). The following points apply as regards the use of FSMP for MNT:

- When a FSMP is used as the sole source of nutrition the product used must be nutritionally complete, providing the full range of required macro- or micronutrients to match requirements. Where, due to the nature or composition of the FSMP to be used for a specified disease or condition, it is not possible to provide a nutritionally complete formulation, the missing nutrients (usually vitamins and minerals) must be provided alongside the FSMP product in the form of a supplement(s).

- The FSMP used should be clinically appropriate for the disease/condition and the age and nutritional status of the patient being treated, with respect to the formulation, composition, nutrient profile and chemical complexity. In addition, the product should be appropriate to any concomitant conditions such as diabetes, fluid balance or organ dysfunction.
- Parenteral nutrition is not FSMP, but a schedule 3 drug.

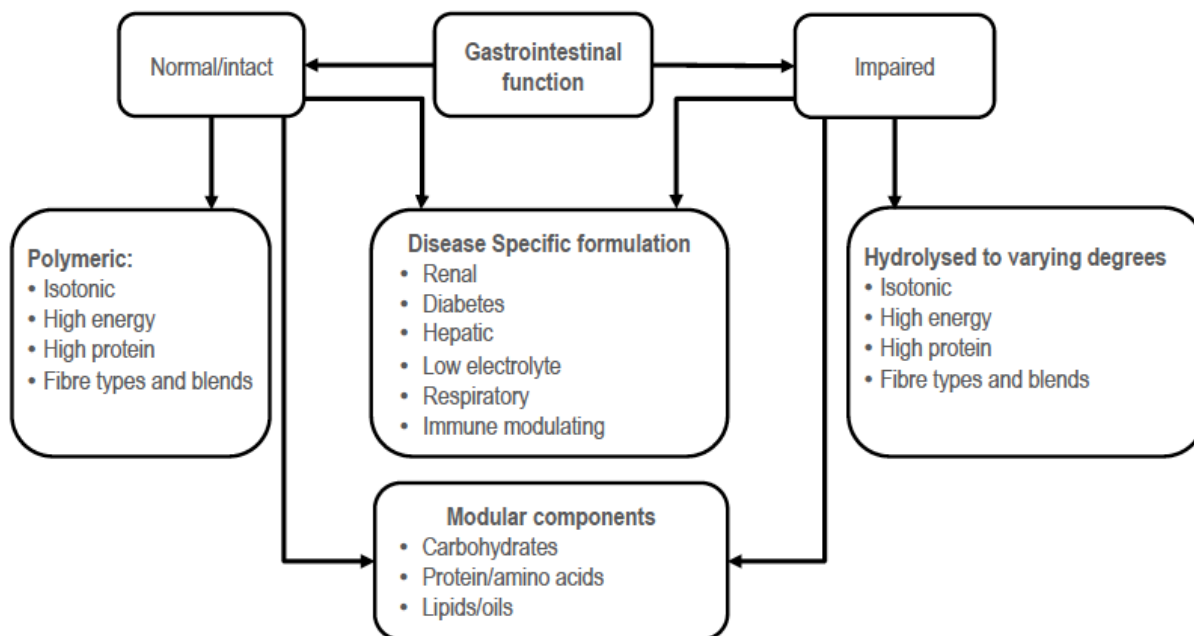


Figure 4. Types and generic features of FSMP formulas for oral and enteral use (adapted from Blaauw and du Toit, 2017)

7. NUTRITION-RELATED PMB level of care FOR PMB CONDITIONS

This section outlines the nutrition-related interventions and MNT to be regarded as PMB level of care for patients with PMB conditions for both adults and paediatrics (infants and children). The PMB entitlements include all and any forms of MNT as well as the minimum consultations with the registered dietitian required to assess, diagnose, prescribe, implement and monitor the applicable MNT.

Table 4. Nutrition-related PMB level of care for PMB conditions related to pregnancy

Entry criteria [apply](#)

52N Pregnancy: Antenatal and obstetric care necessitating hospitalisation, including delivery								
In-hospital only, including high care or ICU								
Diagnosis	Hyperemesis gravidarum with metabolic disturbance OR Late vomiting in pregnancy		Malnutrition in pregnancy		Pre-existing diabetes mellitus OR diabetes mellitus arising in pregnancy	Pre-eclampsia or eclampsia or other form of hypertension during pregnancy	Endocrine, digestive, nutritional and metabolic diseases complicating pregnancy	Any complication of pregnancy, labour or delivery resulting in requirement for MNT e.g. due to intubation, ventilation etc
ICD-10	O21.1, O21.2		O25		O24.0 – O24.9	O10; O11; O14; O15	O99.2, O99.6	Examples: O29; O71; O72; O74; O75; O89; O98
PMB level MNT	Oral intake Nutritional counselling Dietary modification ONS	Oral intake not possible Enteral nutrition	Enteral nutrition not possible Parenteral nutrition	Nutritional counselling Diet modification	Oral intake Nutritional counselling Dietary modification ONS	Oral intake not possible Enteral nutrition	Enteral nutrition not possible Parenteral nutrition	
Products to be provided as part of PMB	Typically, 2-3 units*per day: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR other product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (food for special medical purposes)	Typically, 1-2 litres per day: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate or high protein enteral feed (with or without fibre) OR other product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (food for special medical purposes)	Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug	None	Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR A low electrolyte, low mineral sip feed OR A protein-restricted sip feed OR other product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (food for special medical purposes)	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A disease-specific formula OR other product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (food for special medical purposes)	Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug	
PMB consults with dietitian	3-7 times a week while in hospital depending on severity of illness and complexity of MNT			1 consult while in hospital	3-7 times a week while in hospital depending on severity of illness and complexity of MNT			

where commercial, ready-to-use sip or enteral feeds are substituted for powdered commercial products and used as the sole source of nutrition, it is essential that the powdered substitute be a nutritionally complete medical nutrition supplement (food for special medical purposes) containing a full range of micronutrients prescribed by a dietitian.

Table 5. Nutrition-related PMB level of care for PMB conditions of neonates and infants

Note: The general policy for infant nutrition is the promotion and protection of breastfeeding in line with National Department of Health Policy. However, in the case where breastfeeding is medically contraindicated or impossible or induces metabolic crisis or other clinical conditions apply, specific FSMP products may be prescribed at PMB level of care according to Entry criteria. Ordinary Breastmilk Substitutes (infant formula) are not regulated in the FSMP category and are not PMB level of care.

Entry criteria

DTP	67N Low birth weight <1000g with respiratory difficulties	967N Low birth weight <2500g and >1000 with respiratory difficulties	54N Necrotising enterocolitis in newborn	901N Congenital systemic infections affecting the Newborn	902N Neonatal endocrine, metabolic and toxin-induced conditions	901K Life-threatening congenital abnormalities of carbohydrate, lipid, protein, and amino acid metabolism	911G Liver failure; hepatic vascular obstruction; inborn errors of liver metabolism; biliary atresia
Care Setting	Hospital				Hospital	Hospital and home	
Diagnosis	Extremely low birth weight; Extreme prematurity	Other low birth weight; Other preterm infants	Necrotising enterocolitis of foetus and newborn	Congenital infections and infection in the newborn	Neonatal jaundice	Life-threatening congenital abnormalities of carbohydrate, lipid, protein and amino acid metabolism	
ICD-10	P07.0, P07.2	P07.1,P07.3	P77	P35 – P38	P58 - P59	E70.0 – E70.2, E70.8; E71.0-E71.3; E72.0, E72.1, E74.1; E74.2; E75.0-E75.6;	E70.2, E70.9, E72.0, E72.2-E72.5, E72.9, E74.0, E74.4, E74.8, E77.0, E77.8, E78.6, E78.8, E78.9
PMB level MNT	Oral intake	Oral intake not possible Nasogastric or orogastric feeds Criteria: Respiratory distress Preterm birth <34 weeks gestation Baby unable to suck	Oral intake or enteral formula not possible Parenteral nutrition		Nutrition counselling	Oral or enteral nutrition Highly specific and specialised restrictions, substitutions, modifications and supplementations to the diet depending on the particular inborn error. Complex to manage. Criteria: Breastfeeding contraindicated or induces metabolic crisis OR poor growth/development parameters	
Products to be provided as part of PMB	Human Breastmilk Fortifier OR if breastfeeding impossible or clinically inappropriate: FSMP prescribed by dietitian if clinically indicated		Industry-compounded Schedule 3 drug		None	Age- and growth appropriate volumes of specialised FSMP products designed for metabolic errors, with or without supplemental modules of energy and other macronutrients in various possible combinations.	
PMB consults with dietitian	3-7 times a week while in hospital depending on severity of illness and complexity of MNT				1 consult while in hospital	3-7 times a week while in hospital depending on severity of illness and complexity of MNT Malnourished/poor growth: monthly as out-patient Normal growth: 3-4 times per year as out-patient	

Table 6. Nutrition-related PMB level of care for paediatric PMB conditions involving neurological or development difficulties

Entry criteria apply

DTP	213A Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non-progressive neurological (including spinal) condition or injury	83A Encephalocele; congenital hydrocephalus	902A Epilepsy (status epilepticus, initial diagnosis, candidate for neurosurgery)
Care Setting	Hospital or home	Hospital or home when associated with shunt/surgery episode	Hospital or home
Diagnosis	Cerebral Palsy	Hydrocephalus	Epilepsy
ICD-10	G81-82	Q03.8, Q03.9	G40 – G41
PMB level MNT	Applies to both diagnostic categories:		Oral Intake or enteral nutrition Depending on severity of seizure disorder
	Oral intake Nutritional counselling and modification	Oral intake not possible Enteral nutrition via: Nasogastric tube (short) /PEG (long)	
Products to be provided as part of PMB	1. Thickening agents Criteria for thickening agents: Poor swallow assessed by health professional 2. Age-appropriate volume of: A high energy sip feed (with or without fibre) OR A high energy moderate or high protein sip feed OR A semi-elemental sip feed OR Other product suitable for oral feeding of malnourished children OR An equivalent powdered medical nutrition supplement (food for special medical purposes)#	Age-appropriate volume of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy high protein enteral feed (with or without fibre) OR A semi-elemental feed OR Other product suitable for enteral feeding of malnourished children OR An equivalent powdered nutritionally complete medical nutrition supplement (food for special medical purposes)#	For oral and enteral feeding Ketogenic FSMP products/modules: Age-appropriate volumes of: A very high fat, low carbohydrate feed AND/OR High long-chain or medium-fat oil modules
PMB consults with dietitian	3-7 times a week in hospital depending on severity of illness and complexity of MNT Malnourished/poor growth or severe feeding difficulties: monthly as out-patient Normal growth and clinically stable: 1-2 times per year as out-patient (if required)		3-7 times a week in hospital depending on severity of illness and complexity of MNT Out-patient: 4-6 times per year depending on progress

Where commercial, ready-to-use sip or enteral feeds are substituted for powdered commercial products and used as the sole source of nutrition, it is essential that the powdered substitute be a nutritionally complete medical nutrition supplement (food for special medical purposes) containing a full range of micronutrients prescribed by a dietitian.

Table 7. Nutrition-related PMB level of care for malnutrition (paediatric and adults)

Entry criteria apply

	Paediatrics (age 0-18 years) *		Adults			Paediatrics and adults
DTP	236K Iron deficiency; vitamin and other nutritional deficiencies – life-threatening		236K Iron deficiency; vitamin and other nutritional deficiencies – life-threatening			236K Iron deficiency; vitamin and other nutritional deficiencies – life-threatening
Care Setting	Home/community OR hospital (if complicated by medical conditions)		Hospital or home			Home
Diagnosis	Moderate acute malnutrition	Severe acute malnutrition	Protein-energy malnutrition (all grades)			Life-threatening anaemia
ICD-10	E41 – E46		E41 – E46			D50-D52
PMB level MNT	Oral intake (or via enteral feeding tube if clinically necessary due to poor oral intake) Nutritional counselling and modification Follow WHO 10 steps management protocol		Oral intake Nutritional counselling Dietary modification ONS	Oral intake not possible Enteral nutrition	Enteral nutrition not possible Parenteral nutrition	Oral Intake Nutritional counselling Dietary modification
Products to be provided as part of PMB	Age-appropriate volume of: Ready-to-use therapeutic foods OR Low lactose, low protein feed without fibre of 0.75kcal/ml (F75) for malnourished children OR High protein feed without fibre of 1kcal/ml (F100) for malnourished children OR High energy, lactose free feed of 1.5kCal/ml without fibre OR Enriched supplementary drink/food OR Semi-elemental feed if persistent diarrhoea OR Equivalent high energy powdered FSMP supplement# AND Combined vitamin and mineral complex for malnourished children	Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR A low electrolyte, low mineral sip feed OR A protein-restricted sip feed OR other product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (food for special medical purposes) #	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A disease-specific formula OR other product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (food for special medical purposes) #	Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug	None, unless concomitant with E41-E46	
PMB consults with dietitian	3-7 times a week while in hospital depending on severity of illness and complexity of MNT Out-patient: 1-4 times per month depending on progress in achieving catch-up growth until exit parameters are met		3-7 times a week in hospital depending on severity of illness and complexity of MNT Out-patient: 1-4 times per month depending on progress until exit criteria have been met			1 consult unless of complex cause

	Exit parameters: weight-for-height/length reaches -1 standard deviations or mid upper arm circumference at least 12.5cm		
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**Patients aged 12 and above may be treated using adult MNT products at discretion of dietitian*

Where commercial, ready-to-use feeds are substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian.

Table 8. Nutrition-related PMB level of care for PMBs involving the gastrointestinal tract (paediatrics and/or adults)

Entry criteria apply

DTP	74N		31K	902F		254F	292F	41F	6F
	Neonatal and infant GIT abnormalities and disorders, including malrotation and atresia		Hypoglycaemic coma; hyperglycemia; diabetic ketoacidosis	Gastric or intestinal ulcers with hemorrhage or perforation		Acute diverticulitis of colon	Regional enteritis; idiopathic proctocolitis – acute exacerbations and complications only	Abscess of intestine	Hernia with obstruction and/or gangrene; uncomplicated hernias under age 18
Care Setting	Hospital or home		Home	Hospital		Hospital or home	Hospital	Hospital or home	Hospital if required in association with surgical episode
Diagnosis	Cystic fibrosis		Reactive/alimentary hypoglycaemia	Peptic ulcer disease or gastritis/gastritis/another gastrointestinal ulcer with haemorrhage or perforation		Acute diverticulitis of the colon	Crohn's disease Ulcerative colitis	Gastrointestinal fistula	Diaphragmatic hernia
ICD-10	E84.1 plus P75		E16.1 – E16.2	K25 – K29; K92		K57.2 – K27.8	K50; K51	K63.1; K63.2	K44
PMB level MNT	Oral intake	Oral intake insufficient	Oral intake	Oral intake not possible	Enteral nutrition not possible	Applies to all diagnostic categories			Oral intake
	Nutritional counselling/modification ONS	Enteral nutrition	Nutritional counselling and modification	Enteral nutrition		Oral intake	Oral intake not possible	Enteral nutrition not possible	
Products to be provided as part of PMB	Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR Feed high in medium-chain triglycerides OR	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A disease-specific formula OR Feed high in medium-chain triglycerides	Usually none	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A feed high in medium-chain triglycerides OR A disease-specific formula including fish oil or arginine-enriched	Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug	Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR A feed high in medium-chain triglycerides OR	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A feed high in medium-chain triglycerides OR A disease-specific formula including fish oil or arginine-enriched	Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug	Nutritional counselling and modification

	Other FSMP product as prescribed for specific indications by a dietitian OR An equivalent powdered medical nutrition supplement (FSMP)#	OR other FSMP product as prescribed for specific indications by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (FSMP)#		OR Glutamine-containing feed OR other FSMP product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (FSMP)#		A disease-specific feed including fish oil or arginine-enriched OR other FSMP product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (FSMP)#	OR Glutamine-containing feed OR Other FSMP product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or another organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (FSMP)#		
PLUS (for all diagnostic categories and all forms of MNT) Oral or enteral glutamine supplement in liquid or powder form as prescribed by a dietitian									
PMB consults with dietitian	3-7 times a week while in hospital depending on severity of illness and complexity of MNT Out-patient: Malnourished/nutritional problems: 1-2 times per month until stabilised Clinically Stable: 2-4 times a year if required	Out-patient: 1-2 consults if required	3-7 times a week while in hospital depending on severity of illness and complexity of MNT	3-7 times a week while in hospital depending on severity of illness and complexity of MNT Out-patient/home: Malnourished/significant nutritional problems: 1-4 times monthly Clinically stable: 3-4 times a year if required	Out-patient: 1-2 consults if required				

Where commercial, ready-to-use feeds are substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian.

Table 9. Nutrition-related PMB level of care for cancer PMBs (paediatrics and/or adults)

For adult patients, the following CMS PMB Guidelines for cancers of the [gastrointestinal tract](#), and for [palliative care of cancers](#) also apply and are not in conflict with the below:

Due to the combined effects of cancer itself, the detrimental impact of anti-cancer treatments on nutritional status, nutritional requirements, nutritional intake and appetite, and the development of symptoms and side-effects of treatment which negatively impact upon all aspects of nutrition, MNT is an essential component of cancer care. Pro-active, early, and consistent MNT throughout the cancer healthcare journey is a core part of reducing progression to cancer cachexia, which can in turn be a treatment-limiting or delaying factor or may even necessitate discontinuation of anti-cancer therapy. This in turn can worsen cancer outcomes. Cachexia is not an inevitable consequence of cancer, but late or inadequate MNT intervention reduces the ability to prevent progression to refractory disease-related malnutrition (Arends et al, 2017a; Arends et al 2017b). MNT should be a routine, integrated aspect of any modality of cancer therapy. Some cancer types are associated with higher nutritional risk due to the site and management/treatment strategies.

DTP	952F; 950C; 950D; 950G; 950H; 950J; 950K; 954J; 952J; 950L; 952K; 952L; 953L; 954L; 950B; 954M; 952M; 950A; 950M; 953M;	901S Acute leukemias, lymphomas	910S Multiple myeloma and chronic leukaemias
Care setting	Hospital or home	Hospital or home	Hospital or home
Diagnosis	Various cancers	Acute leukemia/lymphoma	Multiple myeloma and chronic leukemia
ICD-10	Any applicable	Any applicable	Any applicable
PMB level MNT	Applies to all diagnostic categories in adults and paediatrics		
	Oral intake Nutritional counselling and modification ONS	Oral intake not possible Enteral nutrition	Enteral nutrition not possible Parenteral nutrition
Products to be provided as part of PMB under the following circumstances: 1. In surgical patients 1.1. Pre-operative carbohydrate loading 1.2. Pre-operative nutrition optimisation 1.3. Peri-operative nutrition support 1.4. Post-operative nutrition management 2. In all patients undergoing chemo-or radiation therapy 3. In all patients with pre-cachexia, which may present with anorexia and inflammation without discernible weight loss 4. In all patients with entry	Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR A feed high in medium-chain triglycerides OR A disease-specific feed including fish oil or arginine-enriched OR Immune-enhancing feed OR other FSMP product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (FSMP)#	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A feed high in medium-chain triglycerides OR A disease-specific formula including fish oil or arginine-enriched OR Glutamine-containing feed OR Immune-enhancing feed OR Other FSMP product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or another organ dysfunction) by a dietitian OR	Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug

criteria for MNT	An equivalent powdered nutritionally complete medical nutrition supplement (FSMP)#				
	PLUS (for all diagnostic categories and all forms of MNT if gastrointestinal surgery, chemotherapy, or radiation therapy is used): Oral or enteral glutamine supplement 1-3 units daily in liquid or powder form Cost: R50 per unit				
PMB consults with dietitian	In hospital: 3-7 times a week depending on severity of illness and complexity of MNT				
	Out-patient/home:				
	Pre-operative carbohydrate loading	Pre-operative nutrition optimisation	Peri-operative nutrition support	Post-operative nutrition support	During ongoing medical interventions
	1 consult	Early stage or good nutritional status: 1 consult during preparation/work-up for surgery Late stage or disease-related malnutrition: Weekly during work-up for surgery	Early stage or good nutritional status: 2 per month Late stage or disease-related malnutrition: Weekly		Early stage or good nutritional status: 1-2 per month Late stage or disease-related malnutrition: Weekly

Where commercial, ready-to-use feeds are substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian.

Table 10. Nutrition-related PMB level of care for PMB organ dysfunctions (paediatrics and adults)

Entry criteria apply

DTP	911G Liver failure; hepatic vascular obstruction; inborn errors of liver metabolism; biliary atresia	743G Hepatorenal syndrome	325G Acute necrosis of liver	516F Oesophageal varices	910G Calculus of bile duct with cholecystitis	327G Acute pancreatitis	901L End stage renal disease regardless of cause	903L Acute glomerulonephritis and nephritic syndrome	904L Acute and chronic pyelonephritis; renal and perinephric abscess	743G Hepatorenal syndrome	905E Other correctable congenital cardiac conditions	204E Cardiac failure: acute or recent deterioration of chronic cardiac failure	56N Respiratory conditions of newborn	125D Adult respiratory distress syndrome; inhalation and aspiration pneumonias
Care Setting	Hospital or home													
Diagnosis	Acute and sub-acute or chronic liver disease including liver transplantation			Oesophageal varices (all liver causes)	Gallbladder disease	Acute pancreatitis	Acute or chronic renal failure including hepatorenal syndrome with or without renal replacement therapy			Heart Disease Congestive heart disease, cardiomyopathy, congenital heart defects		Respiratory diseases and distress in newborns and in adults including COPD and asthma		
ICD-10	K72.0, K72.1, K72.9			K70; K71; K74; I85	K80-K83	K85	N11 – N12; N14; N15; N18.5, N18.9; I12	N00 – N05; N07	N10 – N12; N15.1	K76.7	Q20-Q26	I11;I50	P22 – P25; P28; Q33	J43-J45, J80
PMB level	Applies to all diagnostic categories in adults and paediatrics													
MNT	Organ dysfunctions and failures lead to specific metabolic, nutritional, fluid, electrolyte and other nutrition-impacting conditions, which worsen and become more complex as disease progresses or develops acute complications. Organ dysfunction is also commonly associated with disease-related malnutrition. Each organ dysfunction presents specific fluid, electrolyte and other nutritional problems, which must be individually managed and will influence choice of MNT products and methods appropriate to manage nutritional risks and metabolic control. It should also be realised that patients who are eligible for organ transplantation and other surgical interventions will respond better if nutritionally optimised to receive such complex and physiologically taxing interventions, with lower risk of clinical complications.													
	Oral intake Nutritional counselling/modification ONS					Oral intake insufficient/inappropriate/contraindicated Enteral nutrition							Enteral nutrition not possible Parenteral nutrition	
Products to be provided as part of PMB	Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR Feed high in medium-chain triglycerides OR Disease specific feed OR					Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate, or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A disease-specific formula OR Feed high in medium-chain triglycerides OR Disease specific feed OR							Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug	

	Feed containing branch-chain amino acids OR Other FSMP product as prescribed for specific indications by a dietitian OR An equivalent powdered medical nutrition supplement (FSMP)#	Feed containing branch-chain amino acids OR other FSMP product as prescribed for specific indications by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (FSMP)#	
PMB consults with dietitian	In hospital: 3-7 times a week depending on severity of illness and complexity of MNT Out-patient: Malnourished or complex nutritional care: 1-2 times per month until stabilised Clinically Stable: 2-4 times a year if required		

Where commercial, ready-to-use feeds are substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian

Table 11. Nutrition-related PMB level of care for PMB chronic diseases of lifestyle (paediatrics and adults)

DTP	901E Hypertension – acute life-threatening complications and malignant hypertension; renal artery stenosis and other curable hypertension	CDL Cardiomyopathy	CDL Hyperlipidaemia	902E Disorders of the arteries: visceral 907E Acute and subacute ischemic heart disease, including myocardial infarction and unstable angina	CLD Diabetes Mellitus Type 1 Diabetes Mellitus Type 2	901A Stroke – due to hemorrhage, or ischaemia 265A Transient cerebral ischaemia; life-threatening cerebrovascular conditions NOS
Care Setting	Hospital (acute events or surgical episodes) or home					
Diagnosis	Hypertension	Cardiomyopathy	Hyperlipidaemia	Coronary artery disease/atherosclerosis including myocardial infarction and	Diabetes (insulin or non-insulin dependent) Including with acute or chronic complications (coma, DKA, gastroparesis, wounds)	Cerebral artery disease and stroke
ICD-10	I10-12; I13; I15	I25.5; I42	E78.0-E78.5	I20-I25, K55	E10; E11; E14, O24.1 – O24.3	I61-I69
PMB level MNT	<p align="center">Applies to all diagnostic categories in adults and paediatrics</p> <p>Nutritional counselling/education and therapeutic dietary modification is a key preventative and therapeutic strategy for management of chronic diseases of lifestyle. Because risk factors such as overweight and obesity along with poor dietary habits are responsible for development and progression of such diseases, MNT plays a crucial role in both primary and secondary prevention, reduction of events, and avoidance of end-stage and irreversible complications. MNT strategies based on oral intake, however, can be complex since poor habits may be entrenched and take time to shift, or may require careful coordination with medical strategies (e.g. new introduction of insulin regimes). In addition, patients may often present with features of more than one lifestyle disease or syndrome or advanced disease, making the MNT more challenging. Patients with these chronic diseases require chronic MNT for optimal disease management. Therefore, simple control of a single metabolic parameter, such as blood glucose or plasma lipids may not be the definitive goal of nutritional intervention in CDLs while other risk factors continue to exist. Nutrition Care Plans for primary and secondary prevention in line with prevailing state level of care.</p>					
Products to be provided as part of PMB	FSMP products for CDLs apply only if Entry criteria are met, typically associated with acute or chronic complications of these diagnoses, or with other PMB conditions.					
PMB consults with dietitian	<p>In hospital: 3-7 times a week depending on severity of illness and complexity of MNT, if required for acute event</p> <p>Out-patient:</p> <p>Malnourished, complex nutritional care, advanced disease or multiple risk factors: 2 times per month until stabilised</p> <p>Clinically stable, but lifestyle risk factors remain or goals not achieved: 3-4 times a year according to Nutrition Care Plan</p>					

Table 12. Nutrition-related PMB level of care for eating disorders (paediatrics and adults)

Entry criteria may apply, but the diagnosis itself prompts medical nutrition therapy, since nutritional intervention is the foundation of treatment. # Where commercial, ready-to-use feeds are

DTP	908T Anorexia nervosa and Bulimia nervosa		
Care Setting	Home/community or hospital		
Diagnosis	Anorexia nervosa and atypical Anorexia nervosa Bulimia nervosa and atypical Bulimia nervosa		
ICD-10	F50.0-F50.3		
PMB level MNT	Oral intake Nutritional counselling and modification This is the mainstay of MNT for patients in this DTP category together with psychiatric or psychological therapy. ONS can be used and is often indicated but is frequently resisted by patients.	Oral intake insufficient or life-threatening complication Enteral nutrition, cautiously Patients are at very high risk of life-threatening refeeding syndrome and should not be provided MNT without expert supervision and monitoring.	Enteral nutrition unsuccessful or contraindicated Parenteral nutrition This would be a relatively unusual intervention but may be necessary especially in life-threatening complications or during pregnancy. Life-threatening refeeding syndrome can occur, and expert nutritional and metabolic monitoring is essential.
Products to be provided as part of PMB	Typically, 2-3 units*per day of: A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate or high protein sip feed OR A semi-elemental sip drink OR Other FSMP product as prescribed for specific indications by a dietitian OR An equivalent powdered medical nutrition supplement (FSMP)#	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR other FSMP product as prescribed for specific indications by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (FSMP)#	Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug
PMB consults with dietitian	3-7 times a week while in hospital depending on severity of illness and complexity of MNT Out-patient: Chronic care is often needed in the region of 4-12 times per year depending on duration and severity, nutritional status and risk parameters.		

substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian

Table 13. Nutrition-related PMB level of care for dysphagia (paediatrics and adults)

Entry criteria apply

DTP	213A	
Care Setting	Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non-progressive neurological (including spinal) condition or injury	
Diagnosis	Hospital or home	
ICD-10	Dysphagia	
PMB level MNT	R13	
PMB level MNT	Oral intake Nutritional counselling/modification ONS	Oral intake not possible Enteral nutrition
Products to be provided as part of PMB	Thickening agents AND/OR Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR other product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (food for special medical purposes)	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A disease-specific formula OR other product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (food for special medical purposes)
PMB consults with dietitian	3-7 times a week in hospital depending on severity of illness and complexity of MNT Out-patient: 3-4 times a year while reliant on medical nutrition therapy or for monitoring of nutritional status	

Where commercial, ready-to-use feeds are substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian

Table 14. Nutrition-related PMB level of care for infectious diseases and inflammatory conditions (paediatrics and adults)

Entry criteria apply

DTP	168S HIV infection	11S Tuberculosis	CDL	CDL & 155E Rheumatoid arthritis with involvement of other organs
Care Setting	Hospital or home		Home	
Diagnosis	HIV/AIDS	Tuberculosis (pulmonary or extra-pulmonary site)	Rheumatoid arthritis (adult or juvenile onset) including with involvement of other organs	
ICD-10	B20-B24	A15 – A19; A31	M06; M08	M05
Care Setting	Hospital or home		Home	
PMB level MNT	Oral intake Nutritional counselling/modification ONS	Oral intake not possible Enteral nutrition	Oral Intake Nutritional counselling/modification	
Products to be provided as part of PMB	Typically, 2-3 units*per day of: A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate or high protein sip feed OR A semi-elemental sip drink OR A disease-specific feed including with fish oil, glutamine, branch-chain amino acids or other immune-enhancing nutrient OR other product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (food for special medical purposes)	Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A disease-specific formula including those with fish oil, glutamine, branch-chain amino acids or other immune-enhancing nutrient OR other product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (food for special medical purposes)		
PMB consults with dietitian	3-7 times a week in hospital depending on severity of illness and complexity of MNT Out-patient/community care: 3-4 times a year if required due to ongoing nutritional risk, malnutrition or nutritional problems. Note: HIV patients on anti-retrovirals may also develop new metabolic abnormalities such as dyslipidaemia or dysglycaemia as a side-effect of medication and require management in line with lifestyle protocols described in Table 12.		Out-patient: 1-2 times per year if required	

Where commercial, ready-to-use feeds are substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian

Table 15. Nutrition-related PMB level of care for traumatic injury (paediatrics and adults)

Entry criteria apply

DTP	112J Toxic epidermal necrolysis and staphylococcal scalded skin syndrome; Stevens-Johnson syndrome	900J Burns, greater than 10% of body surface, or more than 5% involving head, neck, hands, perineum	339C Fracture of face bones, orbit, jaw; injury to optic and other cranial nerves 900D Open fracture of ribs and sternum; multiple rib fractures; flail chest OR other in the context of multiple trauma	277S Anaerobic infections, life-threatening 904S Metastatic infections, septicaemia 903S Deep-seated (excluding nail infections), disseminated and systemic fungal infections ; 356J Pyoderma; body, deep-seated fungal infections 128S Tetanus; anthrax; Whipple's disease	1A Severe / moderate head injury: hematoma / oedema with loss of consciousness
Care Setting	Hospital, step-down facility or home (if ongoing nutritional complications remain or nutritional rehabilitation required)				
Diagnosis	Stevens-Johnson syndrome	Major burns	Fractures	Sepsis	Traumatic head injury
ICD-10	L51.5	; T20-T32	Any applicable	Any applicable	S06; S09; T06
PMB level MNT	Applies to all diagnostic categories in adults and paediatrics				
	Oral intake Nutritional counselling/modification ONS		Oral intake not possible/inadequate/contraindicated Enteral nutrition		Enteral nutrition unsuccessful or contraindicated Parenteral nutrition
Products to be provided as part of PMB	Typically, 2-3 units*per day of: A fat-free, high energy sip feed OR A high energy or energy dense sip feed (with or without fibre) OR A high energy or energy dense, moderate or high protein sip feed OR A semi-elemental sip drink OR A fat free clear fluid sip feed with protein OR A feed high in medium-chain triglycerides OR A disease-specific feed including fish oil or arginine-enriched OR Immune-enhancing feed OR other FSMP product as prescribed for specific indications (such as glucose control, gastrointestinal symptoms or other organ dysfunction) by a dietitian OR An equivalent powdered medical nutrition supplement (FSMP)#		Typically, 1-2 litres per day of: A standard lactose-free enteral feed (with or without fibre) OR A high energy enteral feed (with or without fibre) OR A high energy or energy dense, moderate or high protein enteral feed (with or without fibre) OR A semi-elemental feed OR A feed high in medium-chain triglycerides OR A disease-specific formula including fish oil or arginine-enriched OR Glutamine-containing feed OR Immune-enhancing feed OR Other FSMP product as prescribed for specific indications (such as organ failure, glucose control, gastrointestinal symptoms or another organ dysfunction) by a dietitian OR An equivalent powdered nutritionally complete medical nutrition supplement (FSMP)#		Industry-compounded or multi-chamber parenteral nutrition product Schedule 3 drug
PMB consults with dietitian	3-7 times a week in hospital or step-down facility depending on severity of illness and complexity of MNT Community/home setting: 2-4 times per month during acute post-discharge period if required				

Chronic care of traumatic brain injury with residual deficit: 2 times per year if clinically stable but feeding deficits or nutritional monitoring required

Where commercial, ready-to-use feeds are substituted for powdered commercial products to be used as the sole source of nutrition, the powdered substitute be a nutritionally complete medical nutrition supplement (FSMP) containing a full range of micronutrients prescribed by a dietitian

Table 16. Nutrition-related PMB level of care for palliative care (paediatrics and adults)

A [PMB definition guideline: Medical Nutrition therapy in palliative care \(Adults\)](#) has been developed to outline the nutritional PMB level of care for several incurable, life-threatening or life-limiting and chronic, progressive diseases for adults. That document is the PMB level of care for reference guideline for all adult patients falling in this diagnostic category. A similar definition guide has not been established for paediatrics although the same principles and general approach to health care applies, while diagnoses/conditions included in this definition may differ in children. As with adults, MNT in the palliative care journey can enhance quality of life and functional capacity, while also providing physiological benefits and reduced symptoms as well as reduced psychological distress. In children, the additional factor of optimal growth and development within the parameters of the disease, is improved by good nutritional care.

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