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Coverage Policy

Inpatient hospitalization for the initiation of a ketogenic diet is considered medically necessary for ANY of the following:

- management of refractory epilepsy in individuals under age 19 when there is documented failure of, contraindications to, or intolerance of antiepileptic medication (i.e., polytherapy)
- pyruvate dehydrogenase complex deficiency (PDCD)
- glucose transporter protein deficiency

Overview

This Coverage Policy addresses the ketogenic diet for the treatment of refractory epilepsy and select inborn errors of metabolism.

General Background

The ketogenic diet is a high-fat, low-carbohydrate, low-protein diet that has been used in the treatment of patients with epilepsy that is refractory to conventional medications. The composition of this diet induces ketosis, a physiological state in which fatty acids and ketones are used as the primary source of energy. The exact
mechanism by which the diet obtains seizure control is unknown. Dehydration and acidosis, in addition to ketosis, appear to play a role.

Epilepsy is a chronic disorder characterized by recurrent seizures. Antiepileptic drugs (AEDs) are the first-line treatment for epilepsy. Other treatment options for epilepsy include vagus nerve stimulation and surgical resection. More than half of those with refractory epilepsy are not candidates for resective surgery. In adults, refractory epilepsy is generally defined as the persistence of seizures despite at least two appropriately prescribed AEDs that have been progressively increased in dosage until toxicity has been experienced. In many children, at least three AEDs should be tried before the child is said to have refractory or intractable epilepsy (Wolf and McGoldrick, 2006; Sheth, et al., 2002).

Certain inborn errors of metabolism, such as the glucose transporter protein deficiency syndrome (Glut1-DS) and pyruvate dehydrogenase complex deficiency (PDCD) have also been treated with the ketogenic diet. Glut1-DS is caused by impaired glucose transport into the brain resulting in an epileptic encephalopathy, developmental delay, and a complex motor disorder. In Glut1-DS, a ketogenic diet provides ketones as an alternative fuel to the brain and effectively controls seizures (Klepper, 2005). PDCD is a rare disorder of carbohydrate metabolism and is characterized by an inability to metabolize pyruvate for energy production within the body. Tissues that require the greatest amounts of oxygen (e.g., brain) are most sensitive to deficiencies in the PDC. While ketogenic diets for the treatment of PDCD have yielded variable success rates, this type of diet along with thiamine, is the primary therapy for infants with this condition (Nordli, et al., 2001).

The ketogenic diet is most commonly initiated during a three- to five-day hospitalization. Inpatient hospitalization has been considered important because of potential complications, such as hypoglycemia or other metabolic problems that may occur during the period of fasting and initial administration of the diet. Fasting begins upon admission along with a modest fluid restriction until urinary ketones reach 3+ to 4+, as measured by urine dipsticks. The diet is then started and gradually increased to a full-calorie, ketogenic diet by the fifth day. The diet ratio, or grams of fat to grams of protein plus carbohydrate, is specifically prescribed for each patient. Most patients remain on the diet for at least two years, during which time AEDs may be reduced or discontinued. Potential side effects of this diet include constipation, growth inhibition, kidney stones and, less commonly, prolonged QT syndrome, cardiomyopathy and bruising. Medical contraindications to the ketogenic diet include metabolic disorders with defects in fat or ketone metabolism; mitochondrial disorders; and liver or renal disease. The ketogenic diet is a restrictive medical regimen that requires nutritional counseling, as well as a highly motivated patient and family, in order to maintain compliance. For optimal administration of the ketogenic diet, an interdisciplinary program is recommended, including a neurologist, dietician, nurse and social worker. This dietary method utilizes readily accessible food items, so the patient/family is usually self-sufficient upon discharge from the hospital setting.

The Atkins diet, which is used for weight reduction, has been evaluated as an alternative to ketogenic diet for the treatment of refractory epileptic seizures. The Atkins diet is less restrictive than the traditional ketogenic diet in terms of protein, fluid, and calorie content and also has the ability to induce ketosis (Gaby, 2007). A few small retrospective and prospective uncontrolled studies (n=14–20) have reported that the diet is effective in reducing seizure frequency and is well tolerated with few side effects (Kossoff, et al. 2006; Kang, et al., 2006). Sharma et al. (2013) conducted a randomized controlled trial of 102 children aged 2–14 years who had daily seizures with appropriate use of at least three anticonvulsant drugs were randomized to receive either the modified Atkins diet (n=50) or no dietary intervention (n=52) for a period of three months. The percentage of children with > 90% seizure reduction, and > 50% seizure reduction 52% and 11.5% respectively, was significantly higher in the diet group (p < 0.001). Constipation experienced by those on the diet was the most common adverse event. Although study results suggest a modified Atkins diet may be effective in reducing seizures in the pediatric population, larger studies with longer-term data are needed to determine the role of this diet in the treatment of refractory seizures.

**Literature Review**

In general, inclusion criteria for reported studies of the effects of ketogenic diets have been children with mixed seizure type who failed treatment with 2–3 AEDs. These studies demonstrating the safety and effectiveness of the ketogenic diet have included randomized controlled trials (RCTs) and case series with patient populations ranging from 48–557 (Lambrechts, et al., 2017; Suo, et al., 2013; Caraballo , et al., 2011; Neal, et al., 2008;
The safety and effectiveness of the diet have also been assessed in and is supported by a meta-analysis (Henderson et al. (2006) and several systematic reviews (Martin, et al., 2016; Levy, et al., 2012; Henderson, et al., 2006; Keene, 2006; Levy and Cooper, 2003; Lefebvre and Aronson, 2000).

A Hayes Directory Report reviewed the available evidence (n=17 prospective studies) on the ketogenic diet for refractory seizures. Studies were found to be consistent and demonstrated a reduction in seizure frequency significantly for 33%–90% of primarily pediatric patients. Less evidence was found to support the efficacy of ketogenic diets in adult patients. Complications of the diet included gastrointestinal symptoms, acidosis, and nutritional deficiency in pediatric patients, menstrual irregularities in women, and impaired concentration in adult patients. It was summarized that the ketogenic diet is an effective therapy for patients with seizure disorders who do not respond adequately to AEDs or who have unacceptable side effects from AED treatment (Hayes, 2011; 2015).

Few studies have examined the safety and effectiveness of initiating the ketogenic diet on an outpatient basis. A case series (n=44) by Vaisleib et al. (2004) reported on patients who had outpatient initiation of the ketogenic diet. Outcomes were compared to retrospectively to patients (n=21) who were hospitalized for initiation of the diet. No significant differences were found between the outpatient and inpatient groups regarding seizure control.

There is evidence in the published, peer-reviewed medical to support the safety and effectiveness of the ketogenic diet. However prospective, randomized controlled trials are needed to determine the role of inpatient versus outpatient initiation of the diet. The paucity of evidence investigating the efficacy of ketogenic diet in adult patients with refractory epilepsy is not sufficient to draw conclusions.

Although data supporting the use of the ketogenic diet for pyruvate dehydrogenase complex deficiency (PDCD) and glucose transporter protein deficiency (Glut1-DS) are based on a very limited number of uncontrolled studies, the ketogenic diet has been incorporated into the standard of care for the treatment of both conditions (Weber, et al., 2001; Rowland, 2005).

**Professional Societies/Organizations**

There is no current statement on the use of a ketogenic diet for seizure disorders from the American Academy of Neurology (AAN) or The Child Neurology Society (CNS).

**Use Outside of the US**

The National Institute for Clinical Excellence (NICE) clinical guideline for the management of epilepsy in adults and children states that the ketogenic diet has long been used in the treatment of refractory epilepsy in children, although the exact mechanism of action is unclear. NICE recommends that children and young people with whose seizures have not responded to the appropriate AEDs be referred to a specialist for consideration of the use of a ketogenic diet (NICE, 2012; 2016).

According to consensus recommendations on the ketogenic diet for children from the International Ketogenic Diet Study Group, the diet should be strongly considered in a child who has failed two to three anticonvulsant therapies, regardless of age or gender, and particularly in those with symptomatic generalized epilepsies. It can be considered the treatment of choice for two distinct disorders of brain metabolism, GLUT-1 deficiency syndrome and PDHD. The guidelines also state that the ketogenic diet is probably only of limited benefit in children who are candidates for epilepsy surgery (Kossoff, et al., 2009).

**Coding/Billing Information**

**Note:**

1) This list of codes may not be all-inclusive.
   2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Considered Medically Necessary when criteria in the applicable policy statements listed above are met:**
CPT® Codes | Description
---|---
No specific codes


References


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