

PARENTERAL NUTRITIONAL THERAPY IN THE HOME

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I. DESCRIPTION

Parenteral nutrition (or PN) is the provision of nutritional requirements intravenously, either through a central or peripheral vein. The purpose of initiating parenteral nutritional therapy is to prevent or correct specific nutrient deficiencies and to prevent the adverse effects of malnutrition when the gastrointestinal tract cannot be used effectively or safely.

Generally, the parenteral approach is considered medically necessary only if adequate nutritional intake is not possible via the oral or tube-feeding route.

A daily caloric intake for adults of 20-40kcal/kg is generally sufficient to maintain body weight. If less than 20-30kcal/kg per day it may be considered supplemental.

Parenteral nutritional therapy is covered as defined below for patients with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition.

II. POLICY/CRITERIA

This policy does not apply to parenteral nutritional therapy in the inpatient setting.

- A. Home parenteral nutrition may be considered medically necessary and a covered benefit when the patient has a structural or functional gastrointestinal tract disease or condition (see E below for examples) resulting in insufficient absorption of nutrients to maintain adequate strength and weight that cannot be corrected by modifying the nutrient composition of the enteral/oral diet (e.g., lactose-free) or utilizing pharmacologic means to treat the etiology (e.g., pancreatic enzymes) AND meets one of the following:
1. > 10% loss of body weight over three-months or less,
- OR**
2. Serum albumin concentration less than 3.4 gm/dL.
- OR**
3. The clinical record demonstrates that the patient cannot be maintained on enteral feedings.



- B. Equipment - If the criteria for parenteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are considered medically necessary.
- C. Preauthorization is required. Initial authorization will not exceed three months and continuing authorization is required at least every three months.
- D. Specific malabsorptive conditions include, but are not limited to, the following:
- Crohn's disease
 - Newborn infants with catastrophic gastrointestinal anomalies such as tracheoesophageal fistula, gastroschisis, omphalocele, or massive intestinal atresia
 - Infants and young children who fail to thrive due to short bowel syndrome, malabsorption, or chronic idiopathic diarrhea
 - Short bowel syndrome secondary to massive small bowel resection
 - Prolonged paralytic ileus after major surgery or multiple injuries
 - Radiation enteritis
 - Chronic or severe acute pancreatitis when a feeding tube cannot be placed or tube feeding is not tolerated
 - Hyperemesis Gravidarum (severe hyperemesis during pregnancy) when a feeding tube cannot be placed or tolerated.
 - Obstruction secondary to stricture or neoplasm of the esophagus or stomach, where a feeding tube cannot be placed beyond the obstruction
 - Small bowel obstruction that cannot be bypassed by a feeding tube
 - Malabsorption due to enterocolic, enterovesical, or enterocutaneous fistulas (parenteral nutrition being temporary until the fistula is repaired)
 - Motility disorder (pseudo-obstruction)
- E. Home intravenous parenteral nutrition is considered not medically necessary and **not** a covered benefit, including but not limited to the following circumstances:
1. To increase protein or caloric intake in addition to the patient's daily diet
 2. For routine pre- and/or postoperative care
 3. Patients with functional GI tracts including but not limited to the following:
 - a. Disorders that induce anorexia including cancer
 - b. Swallowing disorders
 - c. A temporary defect in gastric emptying such as a metabolic or electrolyte disorder.



- d. A psychological disorder impairing food intake such as depression or anorexia nervosa.
- e. A physical disorder impairing food intake such as dyspnea of severe pulmonary or cardiac disease.
- f. A side effect of a medication
- g. Renal failure or dialysis.

III. MEDICAL NECESSITY REVIEW

Required Not Required Not Applicable

IV. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS).*
- ❖ **MEDICAID:** *For Medicaid members, this policy will apply.*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*

V. CODING

ICD9 Diagnosis Codes:

These diagnoses may support medical necessity:

- 263.9 Unspecified Protein-Calorie Malnutrition
- 536.3 Gastroparesis
- 537.4 Fistula of stomach or duodenum
- 555.0 Regional enteritis of small intestine
- 555.1 Regional enteritis of large intestine
- 555.9 Regional Enteritis of Unspecified Site
- 560.9 Unspecified Intestinal Obstruction
- 560.81 Intestinal or peritoneal adhesions with obstruction (postoperative)
(postinfection)
- 560.89 Intestinal or peritoneal adhesions with obstruction, other
- 560.9 Unspecified intestinal obstruction
- 565.1 Anal fistula



569.69	Other complication of colostomy or enterostomy
569.71	Pouchitis
569.79	Other complications of intestinal pouch
569.81	Fistula of intestine, excluding rectum and anus
569.83	Perforation of Intestine
569.9	Unspecified Disorder of Intestine
579.3	Other and Unspecified Postsurgical Nonabsorption
643.10	Hyperemesis gravidarum with metabolic disturbance, unspecified as to episode of care
643.11	Hyperemesis gravidarum with metabolic disturbance, delivered
643.13	Hyperemesis gravidarum with metabolic disturbance, antepartum
751.5	Other congenital anomalies of intestine
777.5	Necrotizing Enterocolitis in Fetus Or Newborn
998.6	Persistent postoperative fistula, not elsewhere classified

CPT/HCPCS Codes:

Presence of codes on this list does not guarantee coverage.

B4164	Parenteral Nutrition Solution: Carbohydrates (Dextrose), 50% or Less
B4168	Parenteral Nutrition Solution; Amino Acid, 3.5%, (500 MI = 1 Unit) - H
B4172	Parenteral Nutrition Solution; Amino Acid, 5.5% Through 7%, (500 MI =
B4176	Parenteral Nutrition Solution; Amino Acid, 7% Through 8.5%, (500 MI =
B4178	Parenteral Nutrition Solution: Amino Acid, Greater Than 8.5% (500 MI =
B4180	Parenteral Nutrition Solution; Carbohydrates (Dextrose), Greater Than
B4185	Parenteral nutrition solution, per 10 grams lipids
B4189	Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates
B4193	Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates
B4197	Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates
B4199	Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates
B4216	Parenteral Nutrition; Additives (Vitamins, Trace Elements, Heparin, El
B4220	Parenteral Nutrition Supply Kit; Premix, Per Day
B4222	Parenteral Nutrition Supply Kit; Home Mix, Per Day
B4224	Parenteral Nutrition Administration Kit, Per Day
B5000	Parenteral Nutrition Solution: Compounded Amino Acid and Carbohydrate
B5100	Parenteral Nutrition Solution: Compounded Amino Acid and Carbohydrates
B5200	Parenteral Nutrition Solution: Compounded Amino Acid and Carbohydrate
B9004	Parenteral Nutrition Infusion Pump, Portable
B9006	Parenteral Nutrition Infusion Pump, Stationary
E0791	Parenteral infusion pump, stationary, single or multichannel
A4211	Supplies for self-administered injections

(per diem "S" codes include payment for TPN solution, standard additives, supplies and equipment)

S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
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- S9365 Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
- S9366 Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
- S9367 Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
- S9368 Home infusion therapy, total parenteral nutrition (TPN); more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
- 99601 Home infusion/specialty drug administration, per visit (up to 2 hours);
- 99602 Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)

VI. REFERENCES

1. “Nutritional Support”, Aetna Clinical Policy Bulletin, February 2005. Available on the World Wide Web @ <http://www.aetna.com/cpb/data/CPBA0061.html> (Retrieved December 15, 2005)
2. “Parenteral Nutrition; Home and Intradialytic” Regence Blue Cross Group Medical Policy December 2003. Available on the World Wide Web @ <http://www.regence.com/trgmedpol/alliedHealth/ah06.html> (Retrieved December 15, 2005)
3. “Home Total Parenteral Nutrition” Blue Cross Blue Shield of Massachusetts Medical Policy, May 2005. Available on the World Wide Web @ http://www.bluecrossma.com/common/en_US/medical_policies/fs296.htm (Retrieved December 15, 2005)
4. “Enteral and Parenteral Nutrition Therapy”, Medicare National Coverage Decision. Available on the World Wide Web @ http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=180.2&ncd_version=1&basket=ncd%3A180%2E2%3A1%3AEnteral+and+Parenteral+Nutritional+Therapy (Retrieved December 15, 2005)
5. AdminaStar Federal, Inc (Region B), Local coverage Determination (LCD #L5063), Parenteral Nutrition, CMS Pub. 100-3 (National Coverage



Determinations Manual), chapter 1, section 180.2, Original determination effective date: 10/01/1993, Revision effective date 01/01/2007.

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