



Home Total Parenteral Nutrition for Adults

I. Policy

University Health Alliance (UHA) will reimburse for home Total Parenteral Nutrition (TPN) for adults when determined to be medically necessary and within the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

- A. TPN is covered (subject to Limitations/Exclusions and Administrative Guidelines) for patients with a severe impairment of the alimentary tract that is expected to last one week or longer when the following criteria are met:
1. The patient is unable to maintain weight and strength by only oral intake or tube enteral nutrition due to one of the following:
 - a. The patient has undergone small bowel resection within the past three months leaving five feet or less of small bowel beyond the ligament of Treitz.
 - b. The patient has short bowel syndrome severe enough that the patient has net gastrointestinal fluid and electrolyte malabsorption with enteral losses exceeding 50 percent of an oral/enteral intake of 2.5-3 liters per day, and urinary output is less than one liter per day.
 - c. The patient requires bowel rest for an expected duration of at least one week and is receiving 20-35 cal/kg/day intravenously for treatment of symptomatic pancreatitis with or without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula when tube feeding distal to the fistula is not possible.
 - d. The patient has complete mechanical small bowel obstruction when surgery is not an option.
 - e. The patient is significantly malnourished (10 percent weight loss over three months or less and serum albumin less than or equal to 3.4 gm/dl) and has severe fat malabsorption (fecal fat exceeds 50 percent of oral/enteral intake on a diet of at least 50 grams of fat/day as measured by a standard 72 hour fecal fat test).
 - f. The patient is malnourished (10 percent weight loss over three months or less and serum albumin less than or equal to 3.4 gm/dl) and has motility disturbance of the small intestine and/or stomach which is unresponsive to prokinetic medication (defined as the presence of daily symptoms of nausea and vomiting while taking maximal dose) as demonstrated in one of the following:
 - i. Scintigraphically (solid meal gastric emptying study demonstrates that the isotope fails to reach the right colon within six hours following ingestion). Study must be performed when the patient is not acutely ill and is not on any medication that would decrease bowel motility.
 - ii. Radiographically (barium or radiopaque pellets fail to reach the right colon within six hours after administration). Study must be performed when the patient is not acutely ill and is not on any medication that would decrease bowel motility.

2. If the patient does not meet any of the above criteria then all of the following criteria must be met:
 - a. The maintenance of weight and strength commensurate with the patient's overall health status requires intravenous nutrition and cannot be achieved by both of the following:
 - i. Modifying the nutrient composition of the enteral diet (e.g., lactose free, gluten free, low in long chain triglycerides, substitution with medium chain triglycerides, and provision of protein as peptides or amino acid).
 - ii. Utilizing pharmacologic means to treat the etiology of the malabsorption (e.g., pancreatic enzymes or bile salts, broad-spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility).
 - b. The patient is malnourished (10 percent weight loss over three months or less and serum albumin less than or equal to 3.4 gm/dl).
 - c. A disease and clinical condition have been documented and have not responded to altering the manner of delivery of appropriate nutrients (e.g., slow infusion of nutrients through a tube with the tip located in the stomach or jejunum).
3. The following are examples of moderate abnormalities that require a failed trial of tube enteral nutrition before TPN would be covered:
 - a. Moderate fat malabsorption - fecal fat exceeds 25 percent of oral/enteral intake on a diet of at least 50 grams of fat per day as measured by a standard 72 hour fecal fat test.
 - b. Diagnosis of malabsorption with objective confirmation by methods other than 72 hour fecal fat test (e.g., Sudan stain of stool, d-xylose test).
 - c. Gastroparesis that has demonstrated a) radiographically or scintigraphically as described in criterion above with the isotope or pellets failing to reach the jejunum in three to six hours; or b) by manometric motility studies showing results consistent with an abnormal gastric emptying, and is unresponsive to prokinetic medication.
 - d. Small bowel motility disturbance unresponsive to prokinetic medication, demonstrated by a gastric to right colon transit time between three to six hours.
 - e. Small bowel resection leaving more than five feet of small bowel beyond the ligament of Treitz.
 - f. Short bowel syndrome that is not severe.
 - g. Mild to moderate exacerbation of regional enteritis, or an enterocutaneous fistula.
 - h. Partial mechanical small bowel obstruction when surgery is not an option.
4. The following is the definition of a trial of tube enteral nutrition:
 - a. A concerted effort must be made to place a tube. For gastroparesis, tube placement must be post-pylorus, preferably in the jejunum. Use of a double lumen tube should be considered. Placement of the tube in the jejunum must be objectively verified by radiographic studies or fluoroscopy. Placement via endoscopy or open surgical procedure would also verify location of the tube, however these are not required.
 - b. A trial with enteral nutrition must be made with appropriate attention to dilution, rate and alternative formulas to address side effects of diarrhea.
5. Examples of a failed trial include:

- a. A patient who has had documented placement of a tube in the post-pyloric area continues to have problems with vomiting and on radiographic recheck the tube has returned to the stomach.
 - b. After an attempt of sufficient time (five to six hours) to get a tube into the jejunum, the tube does not progress and remains in the stomach or duodenum.
 - c. Enteral tube feeding with a very slow drip was initially tolerated but vomiting occurred when the rate was increased.
 - d. After placement of the tube in the jejunum and one to two days of enteral tube feeding, the patient develops vomiting and distension.
 - e. After appropriate placement of the tube, enteral nutrition is initiated and the concentration and rate are increased gradually. Over the course of three to four weeks, attempts to increase the rate and/or concentration and/or to alter the formula to reach the targeted intake are unsuccessful, with increase in diarrhea, bloating or other limiting symptoms, and the patient is unable to meet the needed nutritional goals (stabilize at desired weight or gain weight as needed).
- B. Continuation of TPN is covered (subject to Limitations/Exclusions and Administrative Guidelines) when:
1. There is persistence or insufficient improvement of the underlying condition that would permit discontinuation of TPN; or
 2. There is worsening of the underlying condition during attempts to resume oral or enteral feeding; and
 3. There is clinical improvement, i.e., increase in weight and/or serum albumin/prealbumin.
- C. TPN is covered in a patient with the ability to obtain partial nutrition from oral intake or a combination of oral/enteral intake as long as criteria outlined in this policy are met.
- D. Intradialytic parenteral nutrition (IDPN) is covered if the patient meets the criteria for TPN listed above. Additional documentation requirements are listed in section IV of this policy, below.

III. Limitations/Exclusions

- A. TPN is not covered if impairments have an expected duration of less than one week.
- B. TPN is not covered for patients with a functioning gastrointestinal tract whose need for TPN is only due to:
 1. Swallowing disorder;
 2. Temporary defect in gastric emptying such as a metabolic or electrolyte disorder;
 3. Psychological disorder impairing food intake such as depression;
 4. Metabolic disorder inducing anorexia such as cancer;
 5. Physical disorder impairing food intake such as the dyspnea or severe pulmonary or cardiac disease;
 6. Side effect of a medication;
 7. Renal failure and/or dialysis.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

IV. Administrative Guidelines

- A. Prior authorization is required.
- B. Prior authorization requests are often submitted by the IV therapy provider. Physicians, however, must provide IV therapy providers with updated orders, clinical information, and other documentation necessary to meet prior authorization requirements. All of the following documentation must be submitted:
 - 1. Physician's orders/prescription for TPN including expected duration of treatment
 - 2. Clearly identifiable primary and secondary diagnoses
 - 3. Clinical information supporting that the above criteria are met
 - 4. A current nutritional care plan, including patient-specific nutritional goals
 - 5. Amount of oral intake
- C. Prior authorization is required for extension of therapy and must include documentation which demonstrate:
 - 1. Persistence of the condition verified by current clinical notes, new labs, radiologic studies; or
 - 2. Insufficient improvement of the underlying condition that would permit discontinuation of TPN; or
 - 3. Worsening of the underlying condition during attempts to resume oral feedings; and
 - 4. Effectiveness of treatment as evidenced by an improvement in weight and/or serum albumin/pre-albumin.
- D. If there has been no clinical improvement, requests for continued therapy will be denied unless the physician clearly documents the medical necessity for continued TPN and any changes to the therapeutic regimen that are planned – e.g., an increase in the quantity of parenteral nutrients provided.
- E. In order to cover intradialytic parenteral nutrition (IDPN), documentation must be clear and precise to verify that the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. Records should document that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, the patient must be intravenously infused with nutrients. Infusions must be vital to the nutritional stability of the patient and not supplemental to a deficient diet or deficiencies caused by dialysis. Physical signs, symptoms, and test results indicating severe pathology of the alimentary tract must be clearly evident in any documentation submitted. Patients receiving IDPN must meet the TPN coverage criteria listed above.
- F. If the coverage requirements for TPN are met, medically necessary nutrients, administration supplies, and equipment are covered.
- G. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

V. Policy History

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