

**Policy: MP129**

**Section: Medical Benefit Policy**

**Subject: Total Parenteral Nutrition**

**I. Policy:** Total Parenteral Nutrition

**II. Purpose/Objective:**

To provide a policy of coverage regarding Total Parenteral Nutrition

**III. Responsibility:**

- A. Medical Directors
- B. Medical Management

**IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

**V. Additional Definitions**

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

**Medicaid Business Segment**

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:** Total parenteral nutrition (TPN) is a type of nutritional care involving the use of intravenous fluids containing fats, carbohydrates, proteins, vitamins and other substances administered through a centrally placed catheter.

**INDICATIONS:**

Total parenteral nutrition therapy will be considered for coverage in the treatment of malnutrition due to impaired intestinal absorption associated with any of, but not limited to, the following:

- Crohn's disease;
- Obstructing stricture or neoplasm of the esophagus, stomach or intestine;
- Short bowel syndrome secondary to extensive small bowel resection;
- Motility disorder;
- Malabsorption secondary to enterovesical, enterocutaneous or enterocolic fistulas;
- Prolonged paralytic ileus following surgery or injury;
- Newborns with anomalies such as tracheoesophageal fistula, gastroschisis, omphalocele or massive intestinal atresia which prevent or contraindicate oral feeding;
- Infants and children who fail to thrive due to systemic disease or secondary to intestinal insufficiency associated with short bowel syndrome, malabsorption or chronic idiopathic diarrhea;
- Radiation enteritis
- Pancreatitis, with or without pseudocyst
- Hyperemesis gravidarum

**Criteria for determination of medical necessity**

Total Parenteral Nutrition may be considered medically necessary when there has been an evaluation by a physician who is board certified in gastroenterology or nutritional support, a treatment period of 10 days or more is anticipated, and **ANY** of the following criteria are met:

- Absence of a functional and/or usable gastrointestinal tract capable of absorption; or
- Documented inability to receive more than 30% of the caloric intake orally; or
- Documented inability to benefit from tube feedings as a result of malabsorption due to severe pathology of the gastrointestinal tract; or
- A minimum of 750 calories per day will be administered by TPN; or
- A treatment regimen of at least 5 days per week is planned.

**LIMITATIONS:**

Total parenteral nutrition may be considered **medically necessary** in cancer patients expected to have inadequate oral or enteral nutrition intake for more than 10-14 days.

**EXCLUSIONS:**

There is insufficient evidence in the current peer-reviewed, published medical literature to support the indiscriminate use of total parenteral nutrition in well-nourished or mildly malnourished cancer patients undergoing surgery, chemotherapy, or radiotherapy in whom adequate oral intake is anticipated. This is considered **investigational** and is **NOT COVERED**

**Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.**

**CODING ASSOCIATED WITH:** Total Parenteral Nutrition

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.*

**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 (do not use with home infusion codes S9365-S9368 using daily volume scales)

**S9365:** Home infusion therapy, total parenteral nutrition (TPN); one liter per day, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (includes standard TPN formula; lipids, specialty amino acid formulas, drugs, and nursing visits are coded separately), per diem

**S9366:** Home infusion therapy, total parenteral nutrition (TPN); more than one liter per day but no more than two liters per day, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (includes standard TPN formula; lipids, specialty amino acid formulas, drugs, and nursing visits are coded separately), per diem

**S9367:** Home infusion therapy, total parenteral nutrition (TPN); more than two liters per day but no more than three liters per day, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (includes standard TPN formula; lipids, specialty amino acid formulas, drugs, and nursing visits are coded separately), per diem

**S9368:** Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (includes standard TPN formula; lipids, specialty amino acid formulas, drugs, and nursing visits are coded separately), per diem

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

#### **LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.**

#### **REFERENCES:**

American Gastroenterological Association, Medical Position Statement: Parenteral Nutrition. Gastroenterology 121:966-969. 2001.

St. Anthony's Complete Guide to Medicare Coverage Issues. "Parenteral Nutrition Therapy" March 2002. Section 65-10.1; I-98.

American Society for Parenteral and Enteral Nutrition. Specific guidelines for disease - adults. JPEN J Parenter Enteral Nutr 2002 Jan-Feb;26(1 Suppl):61SA-96SA. Available at: [http://www.guideline.gov/summary/summary.aspx?doc\\_id=3633](http://www.guideline.gov/summary/summary.aspx?doc_id=3633)

Samlowski WE, Wiebke G, McMurray M, Mori M, Ward JH. Effects of total Parental Nutrition (TPN) during high-dose interleukin-2 treatment for metastatic cancer. J immunother. 1998 Jan;21(1):65-74.

Herranz Amo F, Garcia Peris P, Jara Rascon J, Moncada Iribarren I, Basquero Gonzalez B, Martin Matinez JC, Diez Cordero JM, Verdu Tartajo F. Usefulness of total parenteral nutrition in radical surgery for bladder cancer. Actas Urol Esp. 1991 Sep-Oct;15(5):429-36.

Rivadeneira DE, Evoy D, Fahey TJ, Lieberman MD, Daly JM. Nutritional support of the cancer patient. CA Cancer J Clin 1998;48:69-80.

CMS National Coverage Determination for Enteral and Parenteral Nutrition Therapy 180.2. Accessed April 13, 2016. <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=242&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Pennsylvania&Keyword=parenteral&KeywordLookUp=Title&KeywordSearchType=And&bc=gAAAAABAAAA&>

Tian F, Heighes PT, Allingstrup MJ, Doig GS. Early enteral nutrition provided within 24 hours of ICU admission: a meta-analysis of randomized controlled trials. Critical Care Med. 2018.

This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 2/04

**Revised:** 4/05(criteria):4/06 (limitations, exclusions &Ref); 4/07

**Reviewed:** 4/08, 4/09, 4/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 4/17, 4/18, 4/19, 4/20