



# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP129**

**Section: Medical Benefit Policy**

**Subject: Total Parenteral Nutrition**

## Applicable Lines of Business

<b>Commercial</b>	<b>X</b>	<b>CHIP</b>	<b>X</b>
<b>Medicare</b>	<b>X</b>	<b>ACA</b>	<b>X</b>
<b>Medicaid</b>	<b>X</b>		

### 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

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- 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.**

**Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

**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

B4164 Parenteral nutrition solution; carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - home mix

B4168 Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - home mix

B4172 Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) - home mix

B4176 Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix

B4178 Parenteral nutrition solution; amino acid, greater than 8.5%, (500 ml = 1 unit) - home mix

B4180 Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) - home mix

B4185 Parenteral nutrition solution, not otherwise specified, 10 grams lipids

B4187 Omegaven, 10 grams lipids

B4189 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix

B4193 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix

B4197 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix

B4199 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, over 100 grams of protein - premix

B4216 Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) home mix per day

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 carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - Aminosyn-RF, NephroAmine, RenAmine - premix

B5100 Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, HepatoAmine – premix

B5200 Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids - FreAmine-HBC - premix

B9004 Parenteral nutrition infusion pump, portable

B9006 Parenteral nutrition infusion pump, stationary

B9999 NOC for parenteral supplies

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.

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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.

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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 Pareteral 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=gAAAABAAAA&>

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European Society for Clinical Nutrition and Metabolism. ESPEN guideline: home parenteral nutrition. 2020

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, 4/21, 4/22, 4/23

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.

