Carol Rees Parrish, M.S., R.D., Series Editor

Understanding Medicare Coverage for Home Enteral Nutrition: A Case-Based Approach

Alyce Newton

Gisela Barnadas

Placement of a feeding tube for home enteral nutrition (HEN) is only one step that is necessary for Medicare patients to receive HEN. Extensive preparation ensures that our patients have what they need to be successful with home tube feedings. Care and use of the tube, optimal formula and supplies, as well as choice of HEN provider, are just a few considerations. Understanding Medicare requirements is one of the challenges in preparing the patient for home. In a case-based approach, this article will begin with documentation required to meet criteria for Medicare coverage. The new Medicare Competitive Bidding Program, which has shown significant cost savings, will be discussed. Finally, resources for alternative and less costly sources of formula and supplies are provided for those patients who do not meet Medicare HEN guidelines.

OVERVIEW

Medicare covers home enteral nutrition (EN) therapy, (or tube feeding) under the Medicare Part B prosthetic device benefit, for beneficiaries residing at a private residence or an institutional facility, when the stay is not covered by Medicare Part A. Medicare beneficiaries are assigned to one of the four Durable Medical Equipment Medicare Administrative Contractor (DME MAC) regions, based on their permanent address. The DME MAC coordinates and administers Medicare policy and provides helpful checklists and information (see Table 1).[1,2]

Alyce Newton, MS RD LDN CNSC, Medical Science Liaison, Fresenius-Kabi USA
Gisela Barnadas, RD MS CNSC, Nutrition Support Specialist, InfuScience/Home Choice Partners: BioScrip Companies

In order for Medicare to cover home enteral nutrition (HEN), the beneficiary must have a permanent (see below) functional impairment of the gastrointestinal tract. Enteral feeding must be reasonable and necessary, and tube feedings are required to maintain weight and strength commensurate with overall health status. If these coverage requirements are satisfied, the related enteral equipment, supplies and nutrients may be covered under Medicare Part B. When the recipient meets the Medicare Enteral Guidelines, and their deductible has been satisfied, Medicare Part B pays 80% of allowable charges for EN. The remaining 20% of the allowed amount is the responsibility of the beneficiary, which may be covered by a supplemental or secondary insurance policy. If the patient does not

(continued on page 13)

(continued from page 10)

meet the Medicare criteria for HEN, the secondary insurance policy may or may not cover home enteral feedings. Many clinicians have summarized practical applications of the Medicare guidelines.[3-5]

The main features of the Medicare Enteral Policy[1,2] include the following coverage guidelines (Table 2): Enteral nutrition is covered for a patient who presents with:

a) Permanent non-function or disease of the structures that normally permit food to reach the small bowel.

OR

b) Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.

Table 1. Resources for Medicare Part B Enteral Guidelines

- **Medicare Claims Processing Manual**
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf (Rev 1/4/13)
- **Medicare Administrative Contractor Jurisdictions Local Coverage Determination (LCD) for Enteral Nutrition:**
  - **Jurisdiction Map:**
    - http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/Jurisdiction-Maps/Specialty_MAC_Jurisdiction_MAP.pdf
  - **Carrier Jurisdictions: go to www.cms.gov and search for the LCD for the jurisdiction (A-D)**
    - **Region A:** National Heritage Insurance Company LCD for Enteral Nutrition (L5041) http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/L5041_2011-08-02_PA_2011-08.pdf
    - **Region B:** Administar Federal LCD for Enteral Nutrition (L27214) http://apps.ngsmedicare.com/applications/content.aspx?docid=134&CatID=3&RegID=51
    - **Region C:** CGS Administrators, LLC LCD for Enteral Nutrition (L11553)
      http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11553&ver=41&ContrId=140&ContrVer=2
    - **Region D:** Noridian LCD for Enteral Nutrition (L11568)
      http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11568&ContrId=139&ver=49&ContrVer=1&CntrctrSelected=139*1&Cntrctr=139&name=Noridian+Administrative+Services+(19003%2c+DME+MAC)&s=56&DocType=All&bc=AggAAAIAAAAAAA%3d%3d&
  - **CMS Enteral Documentation Checklist:**
    - http://www.cgsmedicare.com/jc/coverage/mr/PDF/MR_checklist_EnteralNutrition_int.pdf
  - **Abbott Nutrition**
    - http://static.abbottnutrition.com/cms-prod/abbottnutrition.com/img/9th%20Edition%20Reimbursement%20Manual%20-%20Interactive%20PDF.pdf
    - **Documentation for Specialty Nutrients**
      http://images.abbottnutrition.com/ABBOTT_NUTRITION_2009/MEDIA/Spec%20Nutrient%20Doc%20Checklist%2010.1.12.pdf
  - **Nestlé Health Science Reimbursement Resources and References**
    - http://www.nestle-nutrition.com/reimbursement/default.aspx (includes template letters for medical necessity).
    - http://www.nestle-nutrition.com/nirf/cm2/upload/34032791-C22A-42F6-9A91-E7AE8A405B56/Medicare_Part_B_Coverage_Guidelines_for_Enteral_Nutrition.pdf

Table 2. Basic Criteria for Medicare to Cover Enteral Formula and Supplies[1]

1. Presence of a permanent disorder or condition of the structures that normally permit food to reach the small bowel OR a disease of the small bowel that impairs digestion and absorption of nutrients
   a. Permanent condition defined as > 90 days
2. Adequate nutrition not possible by dietary adjustment and/or oral supplements
3. Formula must go through a tube into the stomach or small intestine
4. Medical documentation required when a special formula or a pump is necessary

Additional Coverage Criteria [1,2] include:

- Permanent impairment (as defined by Medicare). Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (≥ 3 months), the test of permanence is considered met. Enteral nutrition will be denied as non-covered in situations involving temporary impairments (< 3 months).
- The patient's condition could be either anatomic (such as obstruction due to head and neck cancer or esophageal strictures), or due to a motility disorder (such as severe dysphagia following a stroke, or Gastroparesis) (Table 3). For example, the Speech Therapy Swallowing Evaluation or Videofluoroscopic Swallow Study Results documenting dysphagia must be available upon request by Medicare.
- Coverage is possible for patients with partial impairments. For example, a patient with dysphagia who can swallow small amounts of food, or a patient with Crohn's disease or short bowel syndrome, who requires prolonged infusion of enteral nutrients due to malabsorption. Partial conditions must be documented by the prescribing physician (Table 3). The tube feeding must be the primary source of nutrition, however.
- Generally, daily enteral intake of 750 to 2,000 calories is considered sufficient to maintain body weight. Patients with medical complications may require an intake outside this range. The prescribing physician must document the reason for prescribing less than 750 calories per day or more than 2000 calories per day.[2] Examples of both are included in the case studies below.
- A feeding tube is required to administer the formula into the stomach or small intestine. Oral or "sip" feedings are not covered.
- Enteral nutrition may be administered by syringe (bolus), gravity bag, or pump. Most home patients prefer to use a syringe for bolus feedings. Gravity bag feedings are sometimes used for a slower infusion rate. Gravity feedings are also useful with patients or caregivers with poor dexterity who have difficulty managing a syringe. If a pump is ordered, medical necessity must be documented or the pump will be denied as not reasonable and necessary (See Table 4).

Enteral nutrition is *not* covered for patients with a functioning gastrointestinal tract whose need for EN is due to reasons such as anorexia or nausea associated with psychological disorder, end-stage disease, etc., unless it occurs along with anatomic, motility, or a diagnosis as described in Table 3.

According to Medicare, standard enteral formulas that consist of semi-synthetic intact protein/protein isolates (codes B4150 or B4152) are appropriate for the majority of the patients. If a special nutrient formula (codes B4149, B4153-B4157, B4162, and B4162) is necessary to meet unique nutrient needs for specific disease conditions, documentation of the specific condition and the need for the special nutrient is required. Food thickeners (B4100), baby food and other regular grocery products that can be blenderized

Table 3 Examples of Anatomic, Motility and Disease Diagnoses to Support HEN[5]

Dysphagia (787.22) Due to Neurological Disorders, including:

- CVA (437.9)
- Parkinson's disease (332.0)
- Multiple Sclerosis (340)
- Amyotrophic Lateral Sclerosis (335.20)
- Anoxic Brain Damage (348.1)
- Coma (780.01)
- Cerebral Palsy (343.9)
- Subdural hematoma (432.1)

Functional or Structural Issues, which may prevent food from reaching the small bowel, including:

- Dysphagia, pharyngoesophageal phase (787.24)
- Neoplasm of Esophagus (150), Larynx(161), and Tongue (141)
- Esophageal obstruction secondary to cancer or stricture (530.3)
- Gastric Cancer(230.2), Gastric outlet obstruction (537.0)
- Dumping Syndrome (564.2)
- Gastroparesis (536.3)

Intestinal Disorders, including:

- Other Functional Disorders of Intestine (564.89)
- Bowel Obstruction or Stricture (560.9)
- Intestinal Cancer (152.9)

Malabsorptive Disorders, including:

- Malabsorption, unspecified (579.9)
- Crohn's Disease (555.9)
- Chronic Pancreatitis (577.1)
- Bowel Ischemia (557.1)
- Cystic Fibrosis (579.0)

GI Fistulas, ncluding:

- Tracheo-esophageal fistula (750.3)
- Intestinal fistula (569.81)

Diagnoses NOT Covered by Medicare
(unless occur along with anatomic, motility or disease diagnosis as listed above)

- Psychological disorders
- End stage disease with anorexia or nausea
- Failure to thrive
- Dementia
- Dehydration
- Poor appetite, etc.

Table 4. Clinical Conditions to Justify Pump Feedings[1]

- Reflux or aspiration (gravity bag or bolus/syringe feedings not tolerated)
- Severe diarrhea, nausea and vomiting
- Dumping syndrome
- Administration rate < 100mL/hr necessary (provide reason)
- Blood glucose fluctuations
- Risk of volume/circulatory overload
- Jejunostomy tube or small bowel feedings required

and administered through a tube will be denied as noncovered.[1] For example, if a standard polymeric formula is not tolerated, and a hydrolyzed protein formula is required, the medical documentation letter may include information such as:

- Unsuccessful trials of standard formulas (type, rate, feeding method (pump, gravity, syringe)
- Maldigestion (e.g., pancreatic enzyme insufficiency)
- Malabsorption (e.g., diseases such as cystic fibrosis, inflammatory bowel disease)
- Symptoms of gastrointestinal intolerance – (must describe)
- Intolerance to standard formula, such as nausea, diarrhea and vomiting
- Intolerance to intact protein, such as diarrhea, cramping or pain
- Acute gastrointestinal dysfunction
- Gastrointestinal disease-provide description
- Other situations, based on clinical judgment, that the patient would benefit from a peptide based formula
- Malabsorption assessment (e.g., fecal fat, d-xylose)

Adapted from: http://images.abbottnutrition.com/ABBOTT_NUTRITION_2009/MEDIA/Spec%20Nutrient%20Doc%20Checklist%2010.1.12.pdf (Table 1)

Case Studies as a Guide to Medicare Reimbursement of Home Enteral Nutrition

TR is a 72-year-old male with esophageal cancer, weight loss 30lbs. over 6 months, current weight 145lbs. He can swallow very small amounts of soft foods and fluids. An outpatient percutaneous endoscopic gastrostomy tube (PEG) was placed prior to commencement of chemotherapy and radiation treatment. The plan is to start with 3-4 cans standard formula per day (750-1000K cal), and increase to 6 cans per day as it anticipated that his ability to swallow will diminish during aggressive chemo-radiation treatment. The family wants to know if Medicare will pay for the PEG syringe feedings at home

Based on review of the Medicare guidelines, the patient will qualify for syringe feedings due to:

1. ☑Diagnosis of Dysphagia due to anatomic obstruction from Esophageal Cancer
2. ☑PEG feedings- anticipate requirement for at least 90 days, meets the test of permanence.
3. ☑Partial impairment- initially will require documentation that the tube feeding is the primary source of nutrition

Enteral feedings can be started in the home with assessment; education and monitoring by experienced home care clinicians. As Barnadas wrote in Practical Gastroenterology in 2003:

"Implement a system in which your office automatically notifies the dietitian and social worker or care coordinator of the need to assess and implement home EN BEFORE an appointment is made for PEG placement. This will result in appropriate nutrition assessment, financial screening, teaching, coordination of skilled nursing care, and supplies for the patient".[5]

(continued on page 19)

(continued from page 16)

JK is an 80-year-old female, who suffered a stroke 3 months ago, and is currently in a long-term care facility. She has tolerated PEG feedings administered by pump since admission. She has been receiving aggressive physical and speech therapy to improve her oral intake. The speech therapist reports that she is able to swallow nectar-thick liquids and pureed foods with assistance. The RD documents that she is consuming less than 30% of her calories from the pureed foods with thickened liquids. The nutrition goal is to increase her oral intake so that she no longer requires the gastrostomy feedings. The family requests to take her home, and continue with overnight standard formula pump tube feedings of 1000Kcal. Will Medicare cover the home enteral feedings and administration by pump?

Considerations

1. ☑Swallowing Evaluation results in the medical record.
2. ☑Permanence - needs feedings for > 3 months. She has already received tube feedings for nearly 90 days in the long term care facility.
3. ☑Calories - if her tube feedings decrease to less than 750Kcal/day, she will need a letter of medical necessity from her physician to justify continuing the tube feedings, and that the feedings provide the primary source of nutrients.
4. ☒Pump Feedings - may not be covered. Is there a reason why she requires a pump? Is she at risk for aspiration? A trial of syringe or gravity feedings may be required before she is discharged home, with medical necessity documented for pump reimbursement if applicable (see Table 4).

AF, a 52-year-old female with Crohn's Disease, receives Medicare due to her medical disability. She can eat and drink small amounts of liquids, but experiences diarrhea and cramping when she tries to increase her oral food intake. A PEG tube was placed and she was started on standard formula feedings by pump, but experienced cramping and diarrhea at rates over 60ml/hr. The feedings currently supply 720Kcal/day. Does she qualify for Medicare reimbursement?

Considerations

1. ☑ Malabsorption - as a result of Crohn's disease, she has a disease of the small intestine, which impairs digestion and absorption of an oral diet.
2. ☑Permanence - Patient will require feedings for at least 90 days
3. ☑Pump - justified; patient requires < 100mL/hr due to intolerance at rate > 60ml/hr.
4. ☒Partial Impairment: Feedings - < 750Kcal/day. Patient will require documentation in the medical record to support the need for 720Kcal/day to maintain her weight and strength commensurate with her overall health status, and that the feedings provide the majority of the nutrients.

The enteral feedings will most likely be covered, with the primary diagnosis of Malabsorption and the secondary diagnosis of Crohn's Disease, along with a letter of medical necessity from the physician to support the need for the feedings to meet the majority of her nutrient requirements. Attempts should be made to gradually increase the formula rate as tolerated if her oral intake continues to be insufficient to meet her nutrient requirements.

DS is a 92-year-old male, suffering from severe dementia and depression. He has lost over 50 pounds in the 6 months since his wife died, and he has moved in with his daughter and her family. He does not eat the food placed before him, and must be fed. The family would like a PEG tube to be placed, to save them time and worry about his nutrition and hydration. Will Medicare cover tube feedings if a PEG is placed?

Considerations

1. ☒Diagnosis: Dementia, Depression. No anatomic dysfunction.

Medicare will not cover enteral feedings due to lack of anatomic dysfunction, (such as absence of dysphagia), even if he is not feeding himself. The family may need assistance from skilled clinicians regarding how to safely feed him and encourage him to eat meals. If coughing and aspiration occur, a swallowing evaluation could be performed. However, a discussion should

Table 5. Enteral Formula Resources

- **Oley Foundation: http://www.oley.org/equipexchange.html and (800) 776-OLEY**

  The Oley Foundation provides education, networking and support for anyone on home enteral and parenteral nutrition. The website contains a link to "Equipment and Supplies" with a toll-free number. The volunteers at Oley have compiled a list of home tube feeding donors who will ship the formula once payment is received for flat rate box shipping.

- **Outpatient Clinics and Food Banks**

  May have donated formula available, to be collected by the patient. The patient and physician may need to be flexible regarding type of formula. Clinics may also have charitable funds available for enteral formula.

- **Veterans Affairs Benefits**

  If the patient qualifies for VA benefits, the patient may be covered for home enteral feedings, or can obtain them at reduced cost from their local VA hospital. http://www2.va.gov/directory/guide/home.asp?isflash=1

- **Formula Companies**

  Require an application to document financial hardship. The requirements are subject to change.

  - Nestlé Nutrition Patient Assistance Program- http://www.cfri.org/pdf/nestlePatientAssistanceForm.pdf
  - Abbott Patient Assistance Application-http://www.abbottpatientassistancefoundation.org/pdf/Abbott_PAF_Med_Nuts.pdf

- **Retail**

  Store brand tube formulas or oral supplements, meal replacement drinks or breakfast packets mixed with milk, can be all be infused by tube and are often less costly. Work with a RD to ensure nutritional adequacy. Check for coupons and warehouse or store discounts. A cost comparison of common liquid nutritional supplements is available at: www.ginutrition.virginia.edu, under Resources for the Nutrition Support Clinicians.

- **Home Care Companies**

  May be able to negotiate price, and home delivery may be included.

- **On-Line**

  On-line companies such as amazon.com have plenty of choices, but may be expensive and the customer pays shipping costs.

- **Homemade Formulas**

  Work with a Registered Dietitian to ensure nutritional adequacy and food safety.

  - Recipes with calculated nutrient content are available (6) at: www.ginutrition.virginia.edu under Resources for the Nutrition Support Clinician
  - Also Oley Foundation: http://www.oley.org/lifeline/TubetalkSO07.html.

  Homemade formulas often require a vitamin/mineral supplement (liquid or crushed tablet) daily. There is risk of a clogged feeding tube when food and fluids are not thoroughly blenderized and the tube well flushed with water before and after medications and feedings. Blenderized foods may be used to supplement ready to use or milk-based formulas.

occur with the family regarding advanced directives before any medical interventions are performed.

JM is a 69-year-old male, diagnosed with Stage IV Gastric Cancer. A jejunostomy tube was placed due to inability to tolerate an oral diet. He was discharged home on a peptide formula at 60ml/hr over 18 hours, which supplied 25Kcal/kg (1250Kcal/day). A few weeks after he went home, Medicare issued a pre-pay review letter, requesting documentation to support the medical necessity for the EN, pump and supplies. What information is pertinent for Medicare to cover the home jejunostomy feedings?

Considerations

1. ☑Diagnosis: Gastric Cancer (disease of the structures that normally permit the food to reach the small bowel) - documented.
2. ☑Permanence: Anticipated that the patient will require tube feedings >90 days
3. ☑Pump: Has jejunostomy tube - (pump covered).
4. ☒Specialty Peptide Formula: Medicare would cover a standard formula. The use of a peptide formula will require additional documentation of a tube feeding trial to demonstrate intolerance to a standard formula. Medicare will not pay for the tube feedings until the justification for the peptide formula is provided and approved.

LS, an 88-year-old female, with malabsorption, chronic diarrhea and a 30 lb. weight loss over 3 months. She has a history of Congestive Heart Failure. She was able to eat small amounts of foods and fluids, including soup, tea and toast. She refused to have a PEG placed, but was receptive to a nasogastric tube (NGT) for overnight pump feedings. She tolerated a low fat standard formula well via NGT at 80ml/hr (960Kcal) and gained weight and strength. Will she qualify for Medicare HEN reimbursement when she is discharged?

Considerations

1. ☑Partial Impairment: covered due to diagnosis of malabsorption.
2. ☑Documentation required that EN provides the majority of nutrients.
3. ☑Permanence: Feedings required > 90 days.
4. ☑Pump: Documentation required to support (due to CHF and rate <100mL/hr).

She will be covered for home NGT feedings but will need documentation in her medical record of what medications have been tried, and applicable malabsorption test results. Document the diagnosis of

Table 6. CMS Competitive Bidding

CMS Competitive Bidding Fact Sheet

- http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4513&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=competitive&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date

Bidding Areas and Suppliers

- http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home
- DMEPOS enteral suppliers: www.medicare.gov/supplier/home.asp

One Year Competitive Bidding Update 17 April 2012

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf

CHF, and that she requires the feeding pump for a rate <100ml/hr to avoid fluid overload. Verify and report that the feedings provide her primary source of nutrition.

WS, a 69-year-old male with esophageal cancer and Type II diabetes, had a gastrostomy tube placed due to diagnosis of dysphagia by swallowing evaluation and videofluoroscopy. He experienced hyperglycemia on standard formula, and was discharged home with an EN order for 8 cans of Diabetic formula per day by syringe, and water flushes as directed. The bolus feedings supplied 2280Kcal, 114 gm Protein, 28 Kcal/kg/d. A few months after going home, Medicare denied payment for the formula, citing specific reasons. Why was this therapy denied?

Considerations

1. ☑Dysphagia diagnosis-met. Documentation of Dysphagia in Medical Record.
2. ☑Test of Permanence-requires feedings > 90 days - met test of permanence.
3. ☒Specialty Formula for Diabetes – NOT MET. Medicare would cover a standard formula, but use of a diabetic formula required additional documentation of intolerance to standard formula.
4. ☒Calories >2000Kcal/day – NOT MET. Medicare requires additional documentation from the physician to justify the elevated calorie requirements.

A letter of medical necessity is required by the physician, to document that the trial of standard formula caused hyperglycemia, and the use of a diabetic formula improved glycemic control. In addition, medical documentation is required to explain that the patient's increased energy requirements exceed 2000Kcal/day to meet his nutrient needs.

What to Do When a Patient Does Not Qualify for Medicare Reimbursement?

When your patient does not meet the Medicare criteria for HEN and commercial insurance is not available, or will not cover home EN, contact the Registered Dietitian and Social Worker in the hospital, clinic or home care company. They often have experience dealing with these challenges. Consider the following:

1. The patient is currently on a specialty formula - has a standard formula been tried?
2. The patient receives feedings by pump - have gravity/syringe feedings been tried, even for a jejunostomy tube, with low volumes? Intestinal feedings may be tolerated with carefully managed low volume syringe or slow drip gravity bag feedings, with less out-of-pocket costs. Discuss with the Registered Dietitian and patient to design a regimen.
3. Is it possible that the patient will require EN for an extended period of time (> 3 months)? Take into consideration the time the patient has already received EN.

Sometimes the patient may not meet Medicare criteria initially, but subsequent evaluation and additional documentation may lead to qualification. Refer to Table 5 for alternative and less costly sources of formula and supplies. Discuss the potential resources with clinicians including the Registered Dietitian, Social Worker and Nurse.[6]

Recent Changes to Medicare, Including "Competitive Bidding"

HEN has traditionally been provided by a "supplier" or participating home care company that accepts Medicare allowable payment for formula and tube feeding supplies. Under the Competitive Bidding program, Durable Medical Equipment and Prosthetics, Orthotics and Supplies (DMEPOS), suppliers will compete to become Medicare contract suppliers by submitting bids to furnish certain items in Competitive Bidding Areas (CBA).[7] The new, lower payment amounts resulting from the competition will replace the fee schedule amounts for the bid items. By July 2013, 91 major metropolitan areas will be part of the Competitive Bidding Program, and expand to 100% coverage by 2016. A complete list of the 91 areas where the program is expanding to is available at: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home (see Table 6).

CBA suppliers contract with Medicare to provide HEN formula and supplies to Part B participants, at a reduced rate from the current fee schedule. To initiate HEN for a consumer or patient residing in a CBA, the

(continued on page 24)

(continued from page 22)

health care provider can find a list of Medicare contract suppliers by visiting: www.medicare.gov/supplier/home.asp and entering the consumer's ZIP code, or by calling 1-800-MEDICARE.

CMS reports that competitive bidding saved Medicare approximately $202.1 million in 2011, the first year of operation, in the nine areas of the country where the program started. Very few complaints were filed, and no negative impact on beneficiary health status resulted.[8]

Competitive bidding affects only those patients where Medicare Part B is their primary health insurance. Patients with Medicare Advantage, Medicare as a secondary payer, managed care, or commercial insurance, are not affected. CMS has not made any substantial changes to the criteria for Medicare Enteral Reimbursement since 1995. However, the advent of the Competitive Bidding Program may bring changes to the provision of home enteral formula and supplies to patients.[9] The provider can utilize the experience of the hospital, clinic and home care discharge planners, social workers, home care nurses and dietitians to enable the Medicare beneficiaries to obtain coverage and optimal nutrition support, and to remain at home.[10] ■

"My view you know is that the ultimate destination is the nursing of the sick in their own homes…But it is no use to talk about the year 2000."

— *Florence Nightingale, from a letter to Henry Bonham Carter, 1867*

References

1. Local Coverage Determination for Enteral Nutrition-Policy Article-Effective August 2011. http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/L5041_2011-08-02_PA_2011-08.pdf. Accessed 2/17/13.
2. Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). (Rev. 2629, 01-04-13) http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf. Accessed 3/10/13.
3. Greaves J. Medicare Update: Navigating Through Reimbursement of Home Enteral Nutrition Therapy. Support Line 2011;33(1)24-27.
4. Wojtlak FR. Medicare enteral and parenteral reimbursement: requirements for successful coverage and payment. Support Line 2006;28(4):18-23.
5. Barnadas G. Navigating Home Care: Enteral Nutrition – Part One. Practical Gastroenterology 2003;XXVII(10):13.
6. Malone AM. Enteral Formula Selection: A Review of Selected Product Categories. Practical Gastroenterology 2005;XXIX(6):44.
7. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html?redirect=/DMEPOSCompetitiveBid/. Accessed 2/17/13.
8. Press Release 30 January 2013: Fact Sheet for Competitive Bidding. http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4513&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=competitive&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date
9. Parver AK, Mutinsky SE. Enteral Nutrition Reimbursement – The Rationale for the Policy: The US Perspective. In: Elia M, Bistrian B (eds): The Economic, Medical/Scientific and Regulatory Aspects of Clinical Nutrition Practice: What Impacts What? Nestlé Nutr Inst Workshop Ser Clin Perform Program. Nestec Ltd. Vevey/S. Karger AG Basel, 2009;12:53-70.
10. Silver HJ, Wellman NS, Arnold DJ, et al. Older adults receiving home enteral nutrition: enteral regimen, provider involvement, and health care outcomes. JPEN 2004;28(2):92-8.