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Medicare Coverage for Home Parenteral Nutrition – An Oxymoron? Part II

Real Life Case Studies – What Does it Take to Qualify For HPN?

Penny Allen

Physicians and healthcare providers charged with caring for patients requiring home parenteral nutrition (HPN) face increasing pressure to discharge patients earlier from the acute setting. Patients with gastrointestinal (GI) disorders or GI/nutritional complications from cancer treatments and other conditions may require continuation of parenteral nutrition (PN) therapy in the home setting. As the population of Medicare eligible beneficiaries grows, it is often a surprise at the time of discharge that many Medicare patients do not have coverage for HPN and the related medically necessary infusion therapies under the current Medicare system. In this second part of a 2 part series on Medicare policy for HPN, we examine real life Medicare HPN referrals, discuss how to assess if a patient/beneficiary qualifies for coverage, and provide suggestions for alternative options when no coverage for home infusion therapy is provided.

INTRODUCTION

A 67 year old female patient with Stage III ovarian cancer presents with a partial small bowel obstruction and intractable nausea and vomiting; she is referred to a home infusion provider for home parenteral nutrition (HPN) on a Friday afternoon. The patient has Medicare as her primary insurance along with a supplemental policy. The physician and case manager are told:

"I am sorry, your patient does not have coverage for HPN under Medicare."

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In last month's edition, the current (and very outdated) Medicare parenteral nutrition (PN) policy was reviewed, along with a call to action to support the Medicare Infusion Site of Care Act which would provide more meaningful infusion benefits for Medicare beneficiaries.[1] In this article, real life referral case studies will be reviewed. Guidance for the clinician trying to obtain the appropriate supporting documentation to meet coverage criteria for a beneficiary requiring HPN will be provided (see Table 1 for clinical conditions that are unlikely or will not be covered by Medicare). For a review of policy details, see last month's issue with reference tables and checklist.

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Referral 1

Partial small bowel obstruction due to ovarian cancer

1. Possible "Situation" in Medicare policy that HPN would be covered? (All "Situations" referred to in the following referral scenarios are quoted verbatim from Medicare policy).

   Situation D[1,2]

   "The beneficiary has complete mechanical small bowel obstruction where surgery is not an option"

2. **Assessment**

   Since the beneficiary only has a "partial" obstruction, she does not meet Situation D exactly so Medicare deems this a "moderate abnormality".[2]

3. Required for coverage for a "moderate abnormality":

   a. Situation G and H criteria (See Part I of this series for detail).[1,2]

   b. Estimated length of need for HPN documented in the medical record by the attending physician, must be at least 3 months.[2]

   c. A thoroughly documented tube feeding trial. (See Part I of this series for detail).[1,2]

Referral 2

Patient diagnosed with short bowel syndrome (SBS), requiring PN and supplemental hydration after a mesenteric infarct and small bowel resection leaving 3 feet (90 cm) of small intestine. Surgery was 3 weeks ago. Patient has Medicare with a supplemental plan that will only cover the 20% patient copay if Medicare pays for the therapy.

1. Possible "Situation" in the Medicare policy where HPN is covered?

   Situation A[1,2]

   "The beneficiary has undergone recent (within the past 3 months) massive small bowel resection leaving less than or equal to five feet of small bowel beyond the ligament of Treitz"

2. **Assessment**

   Patient may meet criteria for Situation A if

Table 1. Clinical Scenarios Where Home Parenteral Nutrition is Unlikely or Will Not be Covered Under Medicare

Clinical scenarios where it is unlikely that HPN will be covered
• Patient has a functioning GI tract
• General malnutrition
• Failure to thrive
• Hyperemesis gravidarum
• Intractable nausea and vomiting
• Cancer cachexia
• Mechanical issues related to enteral feeding (devices)
• Anorexia nervosa or any other eating disorder
• Patient chooses not to eat for any reason
• Any Medicare deemed "moderate abnormality" without an enteral trial
Clinical scenarios where HPN is not covered by Medicare[2]
• Swallowing disorder
• Temporary defect in gastric emptying such as a metabolic or electrolyte disorder
• Psychological disorder impairing food intake such as depression
• Metabolic disorder inducing anorexia such as cancer
• Physical disorder impairing food intake such as the dyspnea of severe pulmonary or cardiac disease
• Side effect of a medication
• Renal failure and/or dialysis

objective documentation in the medical record supports the initial information provided at time of referral.

3. Required documentation in medical record for Medicare HPN coverage:
   a. Need surgical reports clearly stating there is < 5 feet (150 cm) of small bowel remaining beyond the ligament of Treitz.[2] and
   b. Length of need for HPN must be documented in the medical record and must be greater than 90 days.[2]

Referral 3

Patient referred for HPN with diagnosis of weight loss, intractable nausea and vomiting due to chemotherapy and treatments for pancreatic cancer.

1. Possible "Situation(s)" in the Medicare policy where HPN is covered?

   Unless there is a diagnosis of complete obstruction of the *small* intestine (Situation D), malabsorption (Situation E), or a motility disorder (Situation F) with the objective documentation required that supports any one of those Situations, it is highly unlikely there is coverage for HPN. Medicare will only cover HPN when there is a permanent impairment to the *small* intestine. Weight loss, malnutrition, nausea and vomiting are not covered conditions under the current policy; therefore in the majority of cases, cancer and cancer related complications requiring PN are usually not covered in the home setting.

2. **Assessment**
   a. Review full medical record for any other possible covered Situations (A-F, G and H).[1, 2]
   b. Check for a major medical secondary insurance policy with PN benefits.
   c. Explore other options such as PN coverage in a skilled nursing facility, patient self-pay capability, or the hospital pays the HPN provider a per diem rate (if the hospital understands the value of getting the patient out of the hospital bed and into a less costly site of care).
   d. Check Part D benefits for partial coverage of PN formula understanding that the patient will have a daily copay for pump and supplies.

Referral 4

Patient is s/p gastric bypass procedure over 5 years ago with subsequent multiple abdominal surgeries and complications. Patient has been unable to tolerate oral intake and has lost over 200 lbs., and now weighs 105 lbs. She presents with significant malnutrition including multiple nutritional deficiencies. PN has been initiated, and case management would like her discharged as soon as possible. Due to longstanding disabilities, she has a Medicare replacement plan that follows Medicare PN policy; it also has exclusion criteria for weight loss surgery and complications.

1. Possible "Situation(s)" in the medical policy where HPN is covered?

   Unless there is a diagnosis of SBS (Situation A or B); bowel rest for pancreatitis, enterocutaneous fistula or severe Crohn's flare (Situation C); a complete obstruction of the *small* intestine (Situation D), malabsorption (Situation E), or motility disorder (Situation F) along with objective documentation required to support any one of these Situations, it is highly unlikely there is coverage for HPN. Medicare will only cover HPN when there is a permanent impairment to the *small* intestine. Weight loss and malnutrition are not covered conditions under the current Medicare policy and this patient's insurance plan (which follows the Medicare PN policy) also excludes coverage for complications due to weight loss surgeries.

2. **Assessment**
   a. Review medical record thoroughly for any conditions that may be deemed a "moderate abnormality" if the exact criteria for Situations A-F are not met.
   b. Consider an enteral feeding trial if possible (see Part I of this series).[1]
   c. Check if patient has a major medical secondary policy with HPN benefits.
   d. Explore other options such as PN coverage in a skilled nursing facility, patient self-pay capability, or the hospital pays a HPN provider a per diem rate

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- Care providers should shop for best competitive rate among HPN providers as applicable.

e. Check Part D benefits for partial coverage of PN formula (understanding that the patient will have a daily copay for pump and supplies).

f. Check to see if an outpatient infusion center would consider providing PN for a specific number of days/week. Not ideal or convenient for the patient due to the length of time to administer PN. Medicare replacement plans can vary greatly in regards to coverage.

3. Requirements for coverage if there is a "moderate abnormality" as defined by Medicare:

See Part I of this series.[1, 2]

"Beneficiaries who do not meet criteria A-F must meet criteria 1-2 (modification of diet and pharmacologic intervention) PLUS criteria G and H below:

- *G. The beneficiary is malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl), and*
- *H. A disease and clinical condition has been documented as being present and it has 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)."*

Referral 5

Patient with chronic pancreatitis and malabsorption referred for HPN. The case manager wants a discharge today and the patient has Medicare and a Blue Cross secondary insurance plan.

1. Possible "Situation(s)" in the Medicare policy where HPN is covered?

Situation C

Includes three scenarios under "bowel rest" category, one of which is symptomatic pancreatitis with or without pseudocyst:

"The beneficiary requires bowel rest for at least 3 months and is receiving intravenously 20-35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula isn't possible".[1,2]

2. **Assessment**

Patient has the possibility for coverage under Medicare for HPN. Conduct a thorough medical chart review to assess if the documentation exists to support criteria for "symptomatic pancreatitis with or without pseudocyst," i.e., cannot only have a history of pancreatitis, the pancreatitis must be the active problem causing the patient to require PN, and it must be documented that bowel rest is indicated. The words "bowel rest" must be in the medical record, even if NPO (nil per os) status is documented. If documentation does not exist, therapy is expected to be < 3 months, or the patient is not on bowel rest; the secondary Blue Cross (BC) insurance should be investigated concurrently to ascertain if there is coverage under the BC policy if HPN is not covered under Medicare. If the patient is eligible for HPN benefits, and the patient does not meet Medicare criteria, then Medicare would still need to be billed for a specific type of denial code in order to bill the Blue Cross plan.

3. Required documentation in medical record for Medicare HPN coverage:

a. Statement in medical record by attending physician that bowel rest is required for greater than 3 months.[2]

b. PN prescription provides 20-35 cal/kg of actual body weight/day, or there is documentation from the attending physician in the record explaining why calories fall outside of the range.[2]

c. Diagnosis must be symptomatic pancreatitis (not a history of pancreatitis).[2]

Referral 6

Patient with longstanding SBS for years, previously

on HPN and weaned off. After 6 months with no PN, the patient is admitted to the hospital in acute renal failure with weight loss, electrolyte abnormalities and a high output ileostomy. The patient turned 65 years old during the time off PN and now has Medicare with a supplemental insurance policy. The medical team has started the patient on PN in the hospital, corrected the fluid and electrolyte abnormalities and brought renal status back to baseline. They would like the patient to go home on PN and supplemental hydration.

1. Possible "Situation(s)" in the Medicare policy where HPN is covered?

Situation A[1,2]

"The beneficiary has undergone recent (within the past 3 months) massive small bowel resection leaving less than or equal to 5 feet of small bowel beyond the ligament of Treitz, or"

Situation B[1,2]

"The beneficiary has a short bowel syndrome that is severe enough that the beneficiary has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5-3 liters/day the enteral losses exceed 50% of the oral/enteral intake and the urine output is less than 1 liter/day"

2. **Assessment**

If a patient has been off PN for greater than 60 days, Medicare deems this a "break in service" and the patient must be requalified all over again. This patient does have SBS, but if the records reveal there have been no new bowel resections in the last 90 days, then Situation A is not an option--the surgery which left the patient with < 5 feet (150cm) of small intestine was over 3 months ago. The entire medical record should be reviewed to assess if the objective information is available to meet Situation B.

Medicare does not cover hydration therapy; therefore supplemental hydration would not be covered.[3]

3. Required documentation in medical record for Medicare HPN coverage:

   a. Diagnosis of short bowel syndrome.

   b. Statement of length of need for HPN by the attending physician (must be > 3 months).

   c. Lab records: abnormal electrolytes upon admission to the hospital.

   d. An intake and output (I & O) flow chart documenting:

   - Oral/enteral intake of 2.5-3.0 liters/day
   - > 50% of the above intake as output/enteral losses (i.e., > 1250-1500 mL/day), and
   - Urine output must be < 1 liter (It is advantageous to minimize IV fluid intake during the 24 hour time period the I & O is documented, so as not to increase urine output over what it would be at home).

4. Challenges with Situation B:

   a. Electronic medical record I & O charts often do not demonstrate clear delineation of IV intake vs. oral/enteral intake. If not clearly documented all I & O should be done manually so the results are accurate and easy to interpret in preparation for future audits with CMS.

   b. If the patient was given multiple liters of intravenous fluids at the time of admission, urine output may initially be greater than 1 liter, which would not meet Medicare's criteria. Once the patient is stabilized, a detailed I & O should be repeated to allow for a more true assessment of a lower urine output in the setting of short bowel syndrome if the patient were on an oral/enteral diet only.

   c. Many patients who are ill cannot consume 2.5-3 liters orally or enterally, however, under Medicare policy, there is no exception to this, so if the patient cannot consume (or infuse enterally) at least 2500 mL, then there would be no coverage under Situation B.

5. Options for provision of supplemental hydration:

   a. Self-pay pricing for supplemental hydration (healthcare providers and patients should shop around for best pricing if possible).

b. Determine if a higher volume PN solution is possible and would meet the patient's needs. Stability of a more dilute PN solution may be an issue, but there are options to address this.

c. Patient goes to an outpatient infusion center (usually Monday–Friday operations) where Medicare would pay for the infusion.

d. Check for additional major medical policies where hydration (and PN) is usually a covered benefit.

e. During open enrollment periods (October–December), the patient has the option to select another type of Medicare plan which covers home infusion, understanding they may need home infusion for the long term and benefits under straight Medicare are limited. Medicare.gov lists options per zip code for the individual beneficiary.

Referral 7

69 year old female with SBS with < 6 feet of small bowel (exact amount not quantified in the medical record) and one-third of the distal colon remaining. She has been able to maintain the low end of ideal body weight range, but has had multiple admissions for dehydration. Patient cannot maintain urine output > 800mL/day; when more fluid is consumed, stool output increases. Creatinine levels have been slowly rising with levels ranging between 1.3 to 1.5mg/dl. When the patient gets admitted for dehydration and receives IV fluids, the creatinine drops to 1.1-1.2. The patient

Table 2. Guidance for Clinicians Involved with Coordinating HPN for Medicare Beneficiaries

- Document the indication for HPN thoroughly in the medical record for all PN patients:
  - Conduct objective studies as appropriate
  - Add the estimated length of need of the therapy, particularly if the patient will turn 65 soon or may qualify for disability benefits in the future (a patient can qualify for Medicare benefits if they have been disabled for 2 years or longer regardless of age).
- Keep all documentation labeled and in an easily retrievable place in the electronic medical record.
- It is the physician/healthcare team's responsibility to provide thorough, objective documentation as required by the federal government so that each beneficiary (patient) receives the full benefits they are entitled to under the current Medicare system.
- Home PN suppliers can provide consultative guidance as to what is needed to assure coverage under Medicare when possible. Remember this is federal law, not the homecare company's policy. Being angry with the provider does not help when trying to obtain services for a Medicare patient.
- Allow a realistic amount of time for discharge planning so that documentation can be reviewed in a timely manner (i.e., begin discussing with case management and the infusion provider as soon as home PN becomes part of the discharge plan).
- Understand realistically that many patients requiring HPN today will not meet the current, but very dated, Medicare policy requirements and that contingency plans should be discussed and evaluated prior to the day of discharge.
- Think of Medicare policy like the IRS tax code, i.e., there is no gray area, negotiation, outside circumstances, or clinical justifications outside of policy. It is very difficult for clinicians to comprehend and accept that medical necessity has nothing to do with the current policy for HPN under CMS.

requires IV hydration at home to protect renal function and the physicians are asking why this is not possible.

1. Possible "Situation(s)" where HPN or intravenous hydration may be covered?

   Unfortunately, Medicare simply does not cover hydration in the home.[3]

   Options for the patient would be self-pay or when allowed to change Medicare plans (October –December is open enrollment), investigate alternative Medicare Advantage plans in the patient's geographic area that cover home infusion therapy (including hydration and/or PN). Although inconvenient, hydration therapy is covered by Medicare in an outpatient infusion clinic (see above options for provision of supplemental hydration under Referral 6).

2. **Assessment**
   Since the patient does have SBS, Situations A or B may be potential options. Situation A would require an operative report clearly stating how much small bowel is remaining. If a resection resulted in < 5 feet of small intestine beyond the ligament of Treitz, and the resection was in the last 3 months—then there would be coverage.

   If not, we are left with Situation B. If the patient is subsequently admitted again for dehydration, the above guidance and recommendations listed in Referral 6 for Situation B should be followed. This should occur in the institutional setting to ensure clear documentation in the medical record (i.e., the legal document).

   With Situations A, B and D in the Medicare PN policy, the calorie range provision (i.e., PN must provide 20-35 calories/kg of actual body weight) is not required, so if the physician documents clearly what the patient needs are due to her SBS, a more dilute PN prescription may be covered which could meet her fluid and electrolyte needs.

   "NUTRIENTS:
   Parenteral nutrition solutions containing little or no amino acids and/or carbohydrates would be covered only in situations A, B or D discussed in the Parenteral Nutrition - Policy Article
   A total caloric daily intake (parenteral, enteral and oral) of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate body weight. The ordering physician must document in the medical record the medical necessity for a caloric intake outside this range in an individual beneficiary. This information must be available on request".[2]

Referral 8

68 year old obese female with enterocutaneous fistula and wound vac referred for home PN. PN prescription provides 17 calories/kg actual body weight/day. Patient has Medicare for primary insurance and an American Association of Retired Persons (AARP) Medicare supplement policy.

1. Possible "Situation(s)" in the medical policy where HPN is covered?
   Situation C[1,2]
   "The beneficiary requires bowel rest for at least 3 months and is receiving intravenously 20 -35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula is not possible"

2. **Assessment**
   This patient has a chance at Medicare coverage under Situation C depending on a number of variables.

   Required documentation in the medical record for Medicare HPN coverage:

   a. Diagnosis of enterocutaneous fistula in the medical record.[2]

   b. Statement by attending physician that bowel rest is required for at least 3 months. Medicare specifically defers to the language of "bowel rest" not "NPO".[2]

   c. PN prescription must provide 20-35 cal/kg of actual body weight/day. If not, documentation from the attending

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physician explaining why calories fall outside of the range must be in the medical record.[2]

d. Statement that tube feeding distal to the fistula is not possible (a fistulagram or other objective study is helpful, but not mandated by the policy).[2]

CONCLUSION

Until new laws are passed and coverage for home infusion/PN becomes more meaningful under Medicare, healthcare providers must carefully assess the need for HPN therapy. Referrals for homecare should be made as early as possible to allow for thorough examination and review of medical documentation and allow for the possibility that Medicare may require additional testing. This will help ensure that the beneficiary will have coverage for HPN and is not at risk for denial of payment should an audit determine that coverage criteria was not met, potentially leaving the patient and family with a significant bill in the future.

All healthcare providers involved in the care of patients requiring HPN and related therapies should develop a stronger understanding of the Medicare reimbursement system in order to advocate for the needs of this challenging patient population. Failing to do this may prevent patients from having access to life sustaining nutrition support and could also expose them to significant financial harm. Given these risks, clinicians would be well advised to carefully document the clinical necessity of HPN, backed up by objective evidence and testing, along with an estimated length of need for the therapy for all patients going home on PN--as if they needed to meet Medicare criteria. Patients who currently have private insurance may eventually transition to Medicare and supporting documentation will be required for a successful transition and continuation of HPN therapy. More information regarding the Medicare Home Infusion Site of Care Act can be found at **nhia.org**. ■

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