

# MEDICARE TPN QUALIFICATION CHECKLIST

## Core Coverage Criteria

- |    |   |           |          |
|----|---|-----------|----------|
| 1. | Has an enteral trial failed?                            | Yes _____ | No _____ |
| 2. | Have pharmacological means been tried?                  | Yes _____ | No _____ |
| 3. | Will the patient require TPN for a minimum of 3 months? | Yes _____ | No _____ |
| 4. | Will the patient receive between 20 and 35 kcal/kg/day? | Yes _____ | No _____ |

If the answer to any of the above questions is NO, the patient does not meet Medicare's core criteria and payment for therapy will be denied without detailed clinical documentation from the physician justifying medical necessity.

## **If the answer to all above questions is YES, then ONE of the following (A-F) must be a YES:**

- A. Has the patient undergone surgery within the past 3 months leaving < 5 feet of small bowel beyond the ligament of Trietz? Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Does the patient have short bowel syndrome that results in:
- a. Evidence of electrolyte malabsorption, **AND**
  - b. GI fluid intake of 2.5 – 3L / day resulting in enteral losses that exceed 50% of the oral / enteral intake, **AND**
  - c. Urine output of < 1 liter / day? Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Does the patient require bowel rest for at least 3 months, **AND** is receiving intravenously 20 – 35 cal/kg/day for:
- a. Symptomatic pancreatitis with or without pancreatic pseudocyst, **OR**
  - b. Severe exacerbation of regional enteritis, **OR**
  - c. Proximal enterocutaneous fistula where tube feedings distal to the fistula are not possible? Yes \_\_\_\_\_ No \_\_\_\_\_
- D. Does the patient have a complete mechanical small bowel obstruction where surgery is not an option? Yes \_\_\_\_\_ No \_\_\_\_\_
- E. Is the patient malnourished as evidenced by:
- a. 10% weight loss over 3 months or less, **AND**
  - b. Serum albumin < 3.4 gm/DL, **AND**
  - c. Severe fat malabsorption (fecal fat exceeds 50% 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? Yes \_\_\_\_\_ No \_\_\_\_\_
- F. Is the patient significantly malnourished as evidenced by:
- a. 10% weight loss over 3 months or less, **AND**
  - b. Serum albumin < 3.4 gm?DL, **AND**
  - c. Severe stomach motility disturbance of the small intestine and / or stomach which is unresponsive to prokinetic medications and is demonstrated scintigraphically or radiographically? (These studies must be performed when the patient is not acutely ill and is not on any medication which would decrease bowel motility? Yes \_\_\_\_\_ No \_\_\_\_\_

**If the answer to all of A–F was NO, then the patient MUST meet the following:**

Maintenance of weight and strength commensurate with the patient's overall health must require intravenous nutrition and must not be possible utilizing the following approaches:

(Documentation must be provided to substantiate)

1. Modifying the nutrient composition of the enteral diet (i.e. lactose free, gluten free, low in long chain triglycerides, substitution with medium chain triglycerides, provision of protein as peptides or amino acids, etc.), **AND**
2. Utilizing pharmacological means to treat the etiology of the malabsorption (i.e. pancreatic enzymes or bile salts, broad spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, etc.)

**And the following supporting medical policy:**

G. Is the patient malnourished as evidenced by 10% weight loss over 3 months or less and serum albumin < 3.4 gm/DL, **AND** Yes \_\_\_\_\_ No \_\_\_\_\_

H. **Has a disease and clinical condition been documented as being present and it has not responded to altering the manner of delivery of appropriate nutrients through a tube with the tip located in the stomach or jejunum?** Yes \_\_\_\_\_ No \_\_\_\_\_

## Summary of Information

**All patients will fall into one of the following three coverage categories:**

1. The patient meet core coverage criteria **AND** at least one supporting criteria described in A-F. Yes \_\_\_\_\_ No \_\_\_\_\_
2. The patient meets core coverage criteria, does not meet at least one supporting criteria in A-F **BUT DOES MEET** both supporting criteria in G & H. Yes \_\_\_\_\_ No \_\_\_\_\_
3. Patient does not meet coverage criteria for the provision of TPN. Yes \_\_\_\_\_ No \_\_\_\_\_