

**Local Coverage Article:
Parenteral Nutrition - Policy Article (AXXXXX)**

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Rhode Island Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

Article Information

General Information

Article ID

AXXXXX

Original Effective Date

xx/xx/xxxx

Original ICD-9 Article ID

N/A

Revision Effective Date

xx/xx/xxxx

Article Title

Parenteral Nutrition - Policy Article

Revision Ending Date

N/A

Article Type

Article

Retirement Date

N/A

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Article Guidance

Article Text:

NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. “reasonable and necessary”).

Parenteral Nutrition is covered under the Prosthetic Device benefit (Social Security Act § 1861(s)(8)). In order for a beneficiary’s equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met). In addition, there are non-medical necessity coverage and payment rules, discussed below, that also must be met.

TEST OF PERMANENCE

As stipulated in the Medicare *Benefit Policy Manual* (CMS Pub. 100-02) Chapter 15, Section 120, coverage of parenteral nutrition requires that a beneficiary must have a permanent impairment. However, this does not require a determination that there is no possibility that the beneficiary’s condition may improve sometime in the future. If the medical record, including the judgment of the treating practitioner, indicates that the impairment will be of long and indefinite duration, the test of permanence is considered met.

EQUIPMENT AND SUPPLIES:

Only one infusion pump is covered for beneficiaries in whom parenteral nutrition is required.

Additionally, only one supply kit and one administration kit is covered for each day that parenteral nutrition is administered.

When parenteral nutrition is administered in an outpatient facility, the pump used for its administration and IV pole will be denied as not separately payable. The pump and pole are not considered as rentals to a single beneficiary, but rather, as items of equipment used for multiple beneficiaries.

Services associated with the administration of parenteral nutrition in a beneficiary's home are not a covered benefit administered by the DME MACs.

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO Final Rule 1713 (84 Fed. Reg Vol 217)

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provide a list of the specified codes, which is periodically updated. The link will be located here once it is available.

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related Standard Documentation Requirements Article (A55426) will be denied as not reasonable and necessary.

If a supplier delivers an item prior to receipt of a WOPD, it will be denied as not reasonable and necessary. If the WOPD is not obtained prior to delivery, payment will not be made for that item even if a WOPD is subsequently obtained by the supplier. If a similar item is subsequently provided by an unrelated supplier who has obtained a WOPD, it will be eligible for coverage.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Information describing the medical necessity for parenteral nutrition must be available upon request. In order to satisfy the test of permanence, there must be documentation to reflect that in the treating practitioner's judgement, the impairment will be of long and indefinite duration.

Documentation in the medical record shall reflect that the beneficiary has (a) a condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients or (b) disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through and absorbed by the gastrointestinal (GI) system.

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article (A55426), located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS.

MISCELLANEOUS:

Suppliers are required to monitor the beneficiary's medical condition to confirm that the coverage criteria for parenteral nutrition continue to be met.

Parenteral nutrition provided to a beneficiary in a Part A covered stay must be billed by the SNF to the fiscal intermediary. No payment from Part B is available when parenteral nutrition services are furnished to a beneficiary in a stay covered by Part A. However, if a beneficiary is in a stay not covered by Part A, parenteral nutrition is eligible for coverage under Part B and may be billed to the DME MAC by either the SNF or an outside supplier.

DME INFORMATION FORM (DIF)

A DME Information Form (DIF) which has been completed, signed, and dated by the supplier, must be kept on file by the supplier and made available upon request.

The DIF for parenteral nutrition is CMS Form 10126. The initial claim must include an electronic copy of the DIF.

A new Initial DIF is required when parenteral nutrition services are resumed when they are not required for two consecutive months.

A revised DIF must be submitted if:

- Change in HCPCS code for the current nutrient provided.
- Change (increase or decrease) in the calories prescribed for any HCPCS codes other than B4189, B4193, B4197, B4199, B5000, B5100, B5200.
- Change in the number of days per week of administration.
- Change in route of administration.
- When the length of need previously entered on the DIF has expired and the treating practitioner is extending the length of need for the item(s).

CODING GUIDELINES

When homemix parenteral nutrition solutions are used, the component carbohydrates (B4164, B4180), amino acids (B4168, B4172, B4176, B4178), additives (B4216), and lipids (B4185 or

B4187) are all separately billable. When premix parenteral nutrition solutions are used (B4189, B4193, B4197, B4199, B5000, B5100, B5200) there must be no separate billing for the carbohydrates, amino acids or additives (vitamins, trace elements, heparin, electrolytes). However, lipids (B4185 or B4187) are separately billable with premix solutions.

For lipids, one unit of service of code B4185 or B4187 is billed for each 10 grams of lipids provided. 500 ml of 10% lipids contains 50 grams of lipids (5 units of service); 500 ml of 20% lipids contains 100 grams (10 units of service); 500 ml of 30% lipids contains 150 grams (15 units of service).

When an IV pole (E0776) is used in conjunction with parenteral nutrition, the BA modifier should be added to the code. Code E0776 is the only code with which the BA modifier may be used.

For codes B4189, B4193, B4197, B4199, one unit of service represents one day's supply of protein and carbohydrate regardless of the fluid volume and/or the number of bags. For example, if 60 grams of protein are administered per day in two bags of a premix solution each containing 30 grams of amino acids, correct coding is one (1) unit of B4193, not two units of B4189.

For codes B5000, B5100, B5200, one unit of service is one gram of amino acid.

Parenteral nutrition solutions containing less than 10 grams of protein per day are coded using the miscellaneous code B9999.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Coding Information

CPT/HCPCS Codes

N/A

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Revision History Information: Revision History Table

Number	Date	Explanation
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Associated Documents

Related Local Coverage Document(s)

Article(s)

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

LCD(s)

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

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