



Infusion

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Medical Coverage Guidelines for TPN Therapy

Patient: _____

DOB: _____

Core Coverage Criteria:

Has enteral trial failed?	Yes	No
Have pharmacological means been tried (motility agents)?	Yes	No
If NO to either of the above questions, patient does not meet the core coverage criteria. Physician may provide additional supporting explanations as to why tube feeding has not been attempted.		
If YES to both of the above, then <u>one</u> of the following must also be met:		
1. Has the patient undergone surgery within the past three months leaving 5 feet of small bowel beyond the ligament of trietz?	__Yes	__No
2. Does the patient have a severe short bowel syndrome that results in: a. Evidence of electrolyte malabsorption and b. GI fluid of 2.5-3.5 L/day resulting in enteral losses that exceed 50% of the oral/enteral intake and c. Urine output of < 1 liter/day?	__Yes	__No
3. Does the patient require bowel rest for at least three months and is receiving intravenously 20-30 kcal/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 feeding distal to the fistula is not possible?	__Yes	__No
4. Does the patient have a complete mechanical small bowel obstruction where surgery is not an option?	__Yes	__No
5. Is the patient malnourished as evidenced by: a. 10% weight loss over 3 months or less and b. Severe 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 gms of fat/day as measured by a standard of 72 hr fecal fat test)?	__Yes	__No
6. 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? (Their 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 NO to all situations 1-6, 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:

Core Medical Policy:

- Modifying the nutrient composition of the enteral diet (i.e. lactose free, gluten free, low in long chain triglyceries, provision of protein as peptides or amino acids, etc.) **and**
- 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:

7. Is the patient malnourished as evidenced by 10% weight loss over 3 months or less and serum albumin <3.4 gm/dl and	<u> </u> Yes	<u> </u> No
8. Has a disease and clinical condition been documented as being present and it has not responded to altering the manner of delivery appropriate nutrients (i.e. slow infusion of nutrients through a tube with the tip located in the stomach or jejunum)?	<u> </u> Yes	<u> </u> No
Summarize the information:		
1. Patient meets core coverage criteria and at least one supporting criteria described in 1-6.	Yes	No
2. Patient meets core coverage criteria and both supporting criteria described in 7 & 8.	Yes	No
3. Patient does not meet core criteria.	Yes	No

Physician Signature _____

Date: _____