Use of this template is voluntary / optional

Enteral Nutritional Therapy Progress Note Template Guidance

Purpose

This template is designed to assist a physician/Non-Physician Practitioner (NPP)[1] in documenting a progress note for enteral nutrition eligibility and coverage. Medicare requires the provider to document the need for enteral nutrition prior to completion of the Detailed Written Order (DWO). The DWO designates the start of enteral nutrition as a therapy for a Medicare beneficiary who has a confirmed diagnosed medical condition supporting the need for enteral nutritional therapy. Coverage requires use of FDA-approved enteral feeding/infusion kits, pump, supplies, and related nutritional formulas indicated for the treatment of your patients confirmed diagnosed medical condition. This template is available to the clinician and can be kept on file within the patient's medical record or can be used to develop a progress note for use with the system containing the patient's electronic medical record.

Patient Eligibility

Eligibility for coverage of enteral nutrition under Medicare requires a physician/NPP to establish that coverage criteria are met. This helps to ensure the enteral feeding/infusion kits, supplies and related formulas to be provided are consistent with the physician's/NPP's order and supported by the documentation in the patient's medical record.

The physician/NPP must document that the patient has a confirmed diagnosis supporting the need for enteral nutrition to be delivered using FDA-approved feeding/infusion kits, pump, supplies and formulas indicated for the treatment of their medical condition.

National Coverage Determination (NCD) 180.2(B), provides indications for coverage of enteral/parenteral nutritional therapy under Medicare (Note: information in *italics* is quoted directly):

Enteral Nutrition Therapy: *Enteral nutrition is considered reasonable and necessary for a patient with a functioning gastrointestinal tract who, due to pathology to, or non-function of, the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition.*

- Administering and providing enteral therapy:
    - May be given by:
        - Nasogastric,
        - Jejunostomy, or
        - Gastrostomy tubes.

[1] A Medicare allowed NPP as defined is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.

  - Method of administration may be:
    - pump,
    - gravity,
    - syringe, or
    - oral
  - Can be *provided safely and effectively in the home by nonprofessional persons who have undergone special training.*
    - *However, such persons cannot be paid for their services, nor is payment available for any services furnished by non-physician professionals except as services furnished incident to a physician's service.*
- Example: A patient status post (S/P) reconstructive surgery with head and neck cancer and central nervous system disease that severely interferes with the neuromuscular mechanisms of ingestion to the point the patient cannot be maintained with oral feeding.
  - Coverage of enteral nutrition therapy under Part B, for these and any other conditions must be approved on an individual, case-by-case basis and requires the following:
    - *Must have a physician's written order or prescription; and*
    - *Medical documentation (e.g., hospital records, clinical findings from the attending physician) that meets the requirements of the prosthetic device benefit permit and substantiates the patient's condition requires enteral nutrition therapy as medically necessary.*
- Coverage of enteral nutrition therapy under Part B requires:
  - *Medicare pays for no more than one month's supply of enteral nutrients at any one time*.
  - If providing enteral nutrition involves a pump, there must be supporting evidence in the medical documentation to substantiate that the pump is medically necessary; (*i.e., gravity feeding is not satisfactory due to aspiration, diarrhea, dumping syndrome*).
    - *Program payment for the pump is based on the reasonable charge for the simplest model that meets the medical needs of the patient as established by medical documentation.*

    NOTE: *Some patients require supplementation of their daily protein and caloric intake. Nutritional supplements are often given as a medicine between meals to boost protein-caloric intake or the mainstay of a daily nutritional plan. Nutritional supplementation is not covered under Medicare Part B.*

    NOTE: Payment may also be made for formulas necessary for the effective delivery of enteral nutrition as long as the formula is being used with a feeding/infusion kit, supplies that are considered reasonable and necessary for the patient's treatment.

FDA-approved enteral nutrition and related supplies can be accessed on the PDAC website: https://www.dmepdac.com/dmecsapp/do/productsearch;jsessionid=94B0B2C4F3884242AAB8453110AE3D6C

Completing the Enteral Nutritional Therapy Progress Note Template does not guarantee eligibility and coverage but does provide guidance in support of enteral nutrition ordered and billed to Medicare. This template may be used with the Enteral Nutritional Therapy Order Template.

Who can complete the progress note template?

A physician or allowed NPP who is enrolled in Medicare and performed the in-person visit with the patient.

Note: If this template is used:

1) CDEs in black Calibri are required
2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
3) CDEs in blue Times New Roman are recommended but not required

Version R1.0b

DRAFT

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Enteral Nutritional Therapy Progress Note Template

Patient information:

Last name: _____First name: _____MI: _____

DOB (MM/DD/YYYY):_____ Gender: ____M ___F ___Other Medicare ID:_____

Provider (physician/NPP) who performed the evaluation if different than signing provider:

*Last name:*_____*First name:* _____*MI:* ___*Suffix:*_____

*NPI:*_____

Patient diagnoses requiring need for enteral nutrition:

ICD-10-CM	Description	ICD-10-CM	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Enteral nutrition coverage questions:

Does the patient have permanent non-function or disease of the structures that normally permit food to reach the small bowel? _____Yes _____No

If Yes, are tube feedings required to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status? _____*Yes* _____*No*

Is it anticipated the patient's condition (check all that apply):

_____Is not considered a temporary impairment
_____May improve sometime in the future
_____Is of long and indefinite duration (ordinarily at least 3 months)

The patient's condition (check all that apply):

_____Is anatomic (e.g., obstruction due to head and neck cancer or reconstructive surgery, etc.)
_____Is due to a motility disorder (e.g., severe dysphagia following a stroke, etc.) and is not due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc.
_____Is a partial impairment (e.g., a patient with dysphagia who can swallow small amounts of food or has Crohn's disease) that requires prolonged infusion of enteral nutrients to overcome a problem with absorption.

The patient requires enteral nutrition formula feedings (check all that apply):

_____To maintain weight and strength commensurate with the patient's overall health status
_____Because adequate nutrition is not possible with dietary adjustment and/or oral supplements

Is the patient's enteral nutrition therapy being provided in a nursing home, independent living residence, residential home, etc. ___Yes _____No

The patient requires enteral nutrition formula feedings for one or more of the following evidence-based indications (check all that apply):

_____Acute severe pancreatitis
_____Burns
_____Cancer
_____Critically ill
_____Crohn's disease
_____Cystic fibrosis
_____Dementia
_____Gastrointestinal surgery
_____Head injury
_____Liver transplant
_____Older patient, malnourished
_____Short bowel syndrome
_____Stroke (dysphagic)
_____Other

Describe:_____

_____

_____

Specific enteral nutrition requirements:

_____The patient requires a semi-synthetic intact protein/protein isolates enteral formula (appropriate for the majority of patients requiring enteral nutrition)

_____The patient needs a special enteral formula because of the following requirements:

1) _____

2) _____

3) _____

_____The patient has experienced complications associated with syringe or gravity method of administration and a feeding pump is necessary for one or more of the following reasons (check all that apply):

_____Gravity feeding is not satisfactory due to reflux and/or aspiration
_____The patient has severe diarrhea
_____The patient has dumping syndrome
_____The administration rate less than 100 ml/hr.
_____There are wide swings in blood glucose fluctuations
_____There is evidence of circulatory overload
_____A gastrostomy/jejunostomy tube is required to be used for enteral nutrition formula feeding

Chief complaint / history of present illness and associated signs / symptoms:_____

_____

_____

Related past medical / surgical history:_____

_____

Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)

RxNorm	Description	Dose	Frequency	Route	Status

Other medications

Allergies (Include RxNorm if known)

RxNorm	Description	RxNorm	Description

Review of systems (Significant as per history of present problem and need for enteral nutrition):

General:	___weight gain, ___weight loss, ___sleeping problems, ___fatigue, ___fever, ___chills, ___night sweats / diaphoresis ___other:_____
Skin:	___pressure ulcers, ___rashes, ___changes in nails/hair, ___eczema, ___pruritus, ___other:_____
Lymphatic:	___swollen glands/masses: ___in the neck, ___axilla, ____groin, ___other:_____
Head:	___fainting, ___dizziness, ____headaches, ___other:_____
Eyes:	___diplopia, ___glasses/contact lenses, ___redness/discharge, ___blurred vision, ___glaucoma, ___cataracts, ___other:_____
Ears:	___tinnitus, ___discharge, ___hearing loss, ___other:_____
Nose:	___epistaxis, ____sinus infections, ___discharge, ____polyps, ___other:_____
Oral:	___dysphagia, ___hoarseness, ___teeth/dentures, ___other:_____
Neck:	___lumps, ___pain on movement ___other:_____

Breast:	___masses/tumors, ___tenderness, ___discharge, ___gynecomastia, ___other:_____
Pulmonary:	___cough, ___shortness of breath, ___pain, ___wheezing, ___hemoptysis, ___sputum production ___other:_____
Cardiac:	___chest pain, ___palpitations, ___orthopnea, ___murmur, ___syncope ___other:_____
Vascular:	___edema, ___claudication, ___varicose veins, ___thrombophlebitis, ___ulcers ___other:_____
Gastrointestinal:	___swallowing problems, ___abdominal pain, ___constipation, ___diarrhea, ___incontinence, ___nausea, ___vomiting, ___ulcers, ___melena, ___rectal bleeding, ___jaundice, ___heartburn, ___hematemesis ___other:_____
Renal:	___dysuria, ___frequency, ___urgency, ___hesitation, ___flank pain, ___hematuria, ___incontinence, ___nocturia, ___polyuria, ___other:_____
Musculoskeletal:	___pain, ___swelling, ___stiffness, ___limitation of range of motion, ___arthritis ___gout, ___cramps, ___myalgia, ___fasciculation, ___atrophy, ___fracture, ___deformity, ___weakness, ___other:_____
Neurologic:	___seizures, ___poor memory, ___poor concentration, ___numbness / tingling, ___pins and needles sensation, ___hyperpathia, ___dysesthesia, ___weakness, ___paralysis, ___tremors, ___involuntary movements, ___unstable gait, ___fall, ___vertigo, ___headache, ___stroke, ___speech disorders ___other:_____
Psychiatric:	___hallucinations, ___delusions, ___anxiety, ___nervous breakdown, ___mood changes ___other:_____
Hematology:	___anemia, ___bruising, ___bleeding disorders (conditional) ___other:_____
Endocrine:	___heat or cold intolerance, ___diabetes, ___lipid disorders, ___goiter ___other:_____
Other:_____ _____	

Physical examination:

Vital signs: T=_____P=_____R=_____BP=_____/_____Height=_____Weight=_____

General appearance:_____

_____

Head and neck:_____

_____

Chest / lungs:_____

_____

Cardiovascular:_____

_____

Abdominal:_____

_____

Musculoskeletal / extremities:_____

_____

Neurological:_____

_____

Psychiatric:_____

_____

Visual Exam:_____

_____

Other:_____

_____

Physician/NPP assessment / summary:_____

_____

_____

_____

Treatment plan:

_____

_____

_____

_____

Enteral nutrition order:

Estimated length of need in months:_____1-99 (99=lifetime)

Method of administration: ____Syringe ____Gravity ____Pump ____Oral (e.g. drinking)

Days per week administered or infused:_____(1-7)

Order (supply kits, IV pole, pump, feeding tube, etc.) Notes: 1) appendices describe relationship between method of administration and allowed nutrients and supplies, 2) frequency may also be calories per 24-hour period.

Item Description	*Frequency*	*Quantity*	*Refills*

Other:

_____

If nutritional infusion pump is required (need must be documented in the medical record):

_____Stationary _____Portable

Other Orders:

Medications (other than immunosuppressive drugs): _____

_____

Supplies: _____

_____

Investigations (Diagnostic Testing): _____

_____

Consults: _____

_____

Other: _____

_____

_____

Signature, Name, Date and NPI of physician or NPP

Signature: _____

Name (Printed): _____

Date (MM/DD/YYYY): _____ NPI: _____