

Use of this template is voluntary / optional

Parenteral Nutritional Therapy Order Template Guidance

Purpose

This template is designed to assist a physician or Non-Physician Practitioner (NPP)¹ when completing an order for parenteral nutritional therapy solutions, pumps/infusion kits, and supplies to meet the requirements for Medicare eligibility and coverage. This template meets the requirements for the Detailed Written Order (DWO). Coverage requires use of FDA-approved parenteral nutritional therapy solutions, pumps/infusion kits, and supplies, indicated for the treatment of the patient's 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 an order template for use with the system containing the patient's electronic medical record.

Patient Eligibility

Eligibility for coverage of parenteral nutritional therapy under Medicare requires a physician or NPP to establish that coverage criteria are met. This helps to ensure the parenteral nutritional therapy solutions, pumps/infusion kits, and supplies to be provided are consistent with the physician's order and supported by the documentation in the patient's medical record.

The physician or NPP must document that the patient has a confirmed diagnosis supporting the need for parenteral nutritional therapy solution(s) to be delivered using an FDA-approved pump/infusion kits, and supplies indicated for the treatment of their medical condition.

National Coverage Determination (NCD) 100-03, §180.2, provides indications for coverage of enteral/parenteral nutritional therapy under Medicare (Note: information in *italics* is quoted directly):

Coverage of parenteral nutritional therapy under Part B *requires that the beneficiary must have:*

- *A condition involving the small intestine and/or its exocrine glands which significantly impairs absorption of nutrients; or*
- *Motility disorder of the stomach and/or intestine impairing the ability of nutrients to be transported through the GI system.*
 - *The medical record must document objective evidence supporting the clinical diagnosis.*

The beneficiary must have a permanent impairment. Parenteral nutrition will be denied as non-covered in situations involving temporary impairments.

NOTE: Permanence does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long

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.

DRAFT

and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met.

(See the attached Appendices)

FDA-approved parenteral nutritional therapy solutions, pumps/infusion kits and related supplies are listed on the PDAC website: <https://www.dmepdac.com/dmecsapp/>

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

What needs to be specified on the written order?

For parenteral nutritional therapy solutions, pumps/infusion kits and supplies to be covered under the Medicare Durable Medical Equipment, Prosthetic, Orthotic, and Supply (DMEPOS) benefit, according to 1834(a)(11)(B)(i) of the Act, that drug is required to have a written order unless Medicare policy specifies otherwise.

The written order must include at a minimum:

- Beneficiary's name;
- Detailed description of the item(s)² ordered;
- Ordering Physician or NPP name;
- Ordering Physician or NPP signature and signature date; and
- Date of the order (The date of the order if different than the start date).

If the written order is for parenteral nutritional therapy supplies and accessories provided on a periodic basis must include (PIM 5.2.3):

- Item(s) to be dispensed
- Frequency of use
- Duration, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Written orders for parenteral nutrition solutions require the following (PIM 5.2.3):

- Name of the parenteral nutrition solution;
- Concentration (if applicable);
- Dosage;
- Frequency of administration;
- Route of administration; and
- Duration of infusion (if applicable)
- Number of refills (Optional).

² Description can be either a narrative description or a brand name/model number and must include all options or additional features that will be separately billed or that will require an upgraded code

DRAFT

This order template includes information required by the supplier, and typically supplied by the ordering clinician, to complete the DME Information Form (DIF) (CMS-10126 – Enteral and Parenteral Nutrition) required for reimbursement by Medicare.

Who can complete the order template?

A physician or NPP who is enrolled in Medicare and completes the DWO after the beneficiary's need for parenteral nutrition has been established and documented.

Note: If this template is used:

- 1) CDEs in black Calibri are required (includes required information for the DIF)
- 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 R1.0d

DRAFT

Use of this template is voluntary / optional

Parenteral Nutritional Therapy Order Template			
Patient Information:			
Last name: _____		First name: _____ MI: _____	
Address: _____			
City: _____		State: _____	Zip: _____
Telephone number and extension: (____) _____ - _____ x _____			
DOB (MM/DD/YYYY): _____		Gender: __ M __ F __ Other Medicare ID: _____	
Provider (physician or NPP) who performed the evaluation:			
Check here if same as ordering provider: _____			
Last name: _____		First name: _____ MI: _____ Suffix: _____	
NPI: _____			
Patient diagnoses requiring need for parenteral nutrition:			
ICD-10-CM	Description	ICD-10-CM	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Type of order:			
_____ <i>initial</i> _____ <i>resumption therapy after at least two consecutive months</i>			
_____ <i>extension of Length of Need (LON)</i>			
<i>changes in:</i>			
_____ <i>number of days per week administered</i>			
_____ <i>nutrients</i>			
Other: _____			
<i>Order date, if different from date of signature (MM/DD/YYYY): _____</i>			
<i>Start date, if different from date of order (MM/DD/YYYY): _____</i>			
Place of service:			
_____ Patient's home (12)		_____ End Stage Renal Disease facility (ESRD) (65)	
_____ Skilled Nursing Facility (SNF) (31)		_____ Other: _____	
Facility name (if appropriate): _____			
Address: _____			
City: _____		State: _____	Zip: _____
Telephone number and extension: (____) _____ - _____ x _____			

DRAFT

Parenteral nutrition questions:

Estimated length of need in months: _____ 1-99 (99=lifetime)

____ Yes ____ No Does documentation in the medical record support the patient having a permanent disease of structures that normally permit food to reach or be absorbed by the small bowel?

____ Yes ____ No Does documentation in the medical record support the patient having a permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?

Days per week administered: _____ (1-7)

Patient Height: _____ Weight: _____

Order (supply kits, nutrition administration kits, IV pole, pump, etc.) Notes: 1) appendices describe covered nutrients and supplies, 2) frequency may also be calories per 24-hour period.

<i>Item Description</i>	<i>Frequency</i>	<i>Quantity</i>	<i>Refills</i>

Other:

If a parenteral nutrition infusion pump is required (need must be documented in the medical record):
____ *Stationary* ____ *Portable*

Signature, name, signature date, NPI, address, and telephone number

Signature: _____

Name (Printed): _____

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

Address: _____

City: _____ State: _____ Zip: _____

Telephone number and extension: (____) _____ - _____ x _____