

Use of this template is voluntary / optional

Parenteral Nutritional Therapy

Progress Note Template Guidance

Purpose

This template is designed to assist a physician or Non-Physician Practitioner (NPP)¹ in documenting a progress note for parenteral nutritional therapy eligibility and coverage. Documentation to support the need for parenteral nutrition is required for Medicare coverage of parenteral nutritional therapy. Documentation of medical necessity is essential and supports completion of a Detailed Written Order (DWO). The DWO designates the start of parenteral nutrition as a therapy for a Medicare beneficiary who has a confirmed diagnosed medical condition supporting the need for parenteral nutritional therapy. Coverage requires use of FDA-approved parenteral nutritional solution, pump/infusion kits, and supplies 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 parenteral nutritional therapy under Medicare requires a physician/NPP to establish that coverage criteria are met. This helps to ensure the parenteral nutritional solution, pump/infusion kits, and supplies to be provided and used are consistent with the physician's/NPP'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 nutrition to be delivered using FDA-approved solution, 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.*

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

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

(See the attached Appendices)

FDA-approved parenteral nutrition and related supplies can be accessed on the PDAC website:

<https://www.dmepdac.com/dmeapps/>

Completing the Parenteral Nutritional Therapy Progress Note 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 Laboratory Test Results Template and the Parenteral 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 beneficiary establishing and documenting the need for parenteral nutritional therapy.

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 R1.0d

Use of this template is voluntary / optional

Parenteral Nutritional Therapy Progress Note Template			
Patient information:			
Last name: _____ First name: _____ MI: _____			
DOB (MM/DD/YYYY): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Medicare ID: _____			
Provider (physician/NPP) who performed the evaluation if different than signing provider:			
<i>Last name:</i> _____ <i>First name:</i> _____ <i>MI:</i> _____ <i>Suffix:</i> _____			
<i>NPI:</i> _____			
Patient diagnoses requiring need for parenteral nutrition:			
ICD-10-CM	Description	ICD-10-CM	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Parenteral nutritional therapy coverage questions:			
Does the patient have a permanently (at least 3 months) impaired gastrointestinal tract involving the small intestine and/or its exocrine glands which significantly impairs absorption of nutrients; or a motility disorder of the stomach and/or intestine impairing the ability of nutrients to be transported through the GI system? _____ Yes			
_____ No			
<i>If Yes, is there insufficient absorption of nutrients to maintain weight and strength commensurate with the patient's overall health status? _____ Yes _____ No</i>			
<i>Can this be managed with:</i>			
<i>alteration to composition of an enteral diet? _____ Yes _____ No</i>			
<i>using pharmacologic means to treat the etiology of the malabsorption _____ Yes _____ No</i>			
<i>Describe:</i> _____			

Is it anticipated the patient's condition (check all that apply):			
_____ is considered a permanent impairment			
_____ may improve sometime in the future			
_____ is of long and indefinite duration (ordinarily at least 3 months)			

DRAFT

The patient (check all that apply) (note: see Appendix A for specific documentation requirements):

_____ has undergone recent (within the past 3 months) massive small bowel resection leaving less than or equal to 5 feet of small bowel beyond the ligament of Treitz

_____ has short bowel syndrome that is severe enough that the beneficiary has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5-3 liters/day the enteral losses exceed 50% of the oral/enteral intake and the urine output is less than 1 liter/day 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.

_____ requires bowel rest for at least 3 months and is receiving intravenously 20-35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula isn't possible

_____ has complete mechanical small bowel obstruction where surgery is not an option

_____ is significantly malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has very severe fat malabsorption (fecal fat exceeds 50% of oral/enteral intake on a diet of at least 50 gm of fat/day as measured by a standard 72-hour fecal fat test)

_____ is significantly malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has a severe motility disturbance of the small intestine and/or stomach which is unresponsive to prokinetic medication and is demonstrated either:

_____ *Scintigraphically (solid meal gastric emptying study demonstrates that the isotope fails to reach the right colon by 6 hours following ingestion), or*

_____ *Radiographically (barium or radiopaque pellets fail to reach the right colon by 6 hours following administration). These studies must be performed when the patient is not acutely ill and is not on any medication which would decrease bowel motility.*

_____ is malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl), and a disease and clinical condition has not responded to altering the manner of delivery of appropriate nutrients (e.g., slow infusion of nutrients through a tube with the tip located in the stomach or jejunum).

Describe patient condition noted above or other conditions requiring parenteral nutrition:

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

Related past medical / surgical history: _____

DRAFT

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 parenteral 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:

DRAFT

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:	_____

DRAFT

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: _____

Related diagnostic tests

Test Date (MM/DD/YYYY): _____

Fecal fat: _____ g per ____24H; ____72H

Serum Albumen: _____ g/dl

Physician/NPP assessment / summary: _____

DRAFT

Treatment plan:

Parenteral nutrition order:

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

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

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 parenteral 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: _____

DRAFT

Signature, Name, Date and NPI of physician or NPP

Signature: _____

Name (Printed): _____

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