Invited Review

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American Society for Parenteral and Enteral Nutrition

Home Nutrition Support: Ethics and Reimbursement

Nutrition in Clinical Practice
Volume 31 Number 3
June 2016 325–333

DOI: 10.1177/0884533616639128
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Abstract

Ethical dilemmas challenge providers on both sides of the hospital and clinic doors. In addition to establishing the nutrition care plan and guiding the client into the home setting with safe and effective parenteral or enteral nutrition therapy, procuring home nutrition support involves meeting documentation requirements and verifying that clients meet reimbursement criteria for home therapy based on third-party payer criteria. Providers have entered a realm for which training has been scarce and they face moral and ethical dilemmas involving serving as patient advocates, possibly stretching the truth to fit the clinical documentation to criteria vs maintaining professional integrity. Nutrition research and evidence-based practice have outpaced modifications to policies including Medicare's national and local coverage determinations, the bulk of which have not seen revisions in 32 years. This review elucidates clinical dilemmas and urges a political call to action to advocate for changes in current, outdated requirements for reimbursement. Given the current healthcare environment and trend toward expedited hospital stays, patients may be better served (and nourished) with revised guidelines. (*Nutr Clin Pract*. 2016;31:325-333)

Keywords

home nutritional support; medical ethics; public policy; reimbursement; enteral nutrition; parenteral nutrition; home care

The topic of ethics related to nutrition and hydration decisions has garnered its fair share of robust discussion in popular media, conference proceedings, and professional publications, including exploration of case studies, and has been codified by professional organizations[1-5] concerned with these issues. The literature is replete with articles addressing nutrition and hydration related to advanced directives, living wills, and execution of medical power of attorney, among other nutrition support decisions. Clinicians are guided to identify the desires of their patients or clients and support self-determination regarding nutrition support decisions. There is a paucity of literature regarding other ethical challenges faced by nutrition support providers, including those related to planning for post discharge nutrition support and financial reimbursement. This review (1) invites nutrition support practitioners/clinicians to consider their individual practice and challenges they face, including those related to current laws and promulgated rules, to provide and fund home nutrition support; (2) encourages political advocacy to address features that are outdated and do not optimize nutrition care for home nutrition consumers; and (3) poses questions for further contemplation, research, and exploration by nutrition support providers and clinicians, home infusion providers, and the nutrition support community as a whole. Principles of ethics will be integrated into the discussion, because this review aims to address and stimulate dialogue relative to clinical practice in this arena.

Nutrition Care Plan

Moral and ethical dilemmas[3] challenge healthcare workers, and those whose focus is nutrition support are no exception. Moral dilemmas may stem from personal values, character, or conduct of individuals or communities and societies, whereas ethical dilemmas are examined in relation to morality from a broad perspective. Clinical questions such as whether feeding tubes should be inserted for individuals with dementia or those facing terminal illness receive significant discussion in the literature. Other ethical challenges may be unreported, underreported, or potentially unrecognized by those who face or are involved in them. One must be able to label dilemmas, explore them and their effects, and consider options to most effectively deal with the ethical challenge. Disagreements regarding nutrition care plans for patients occur among healthcare team

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Financial disclosure: None declared.

This article originally appeared online on April 12, 2016.

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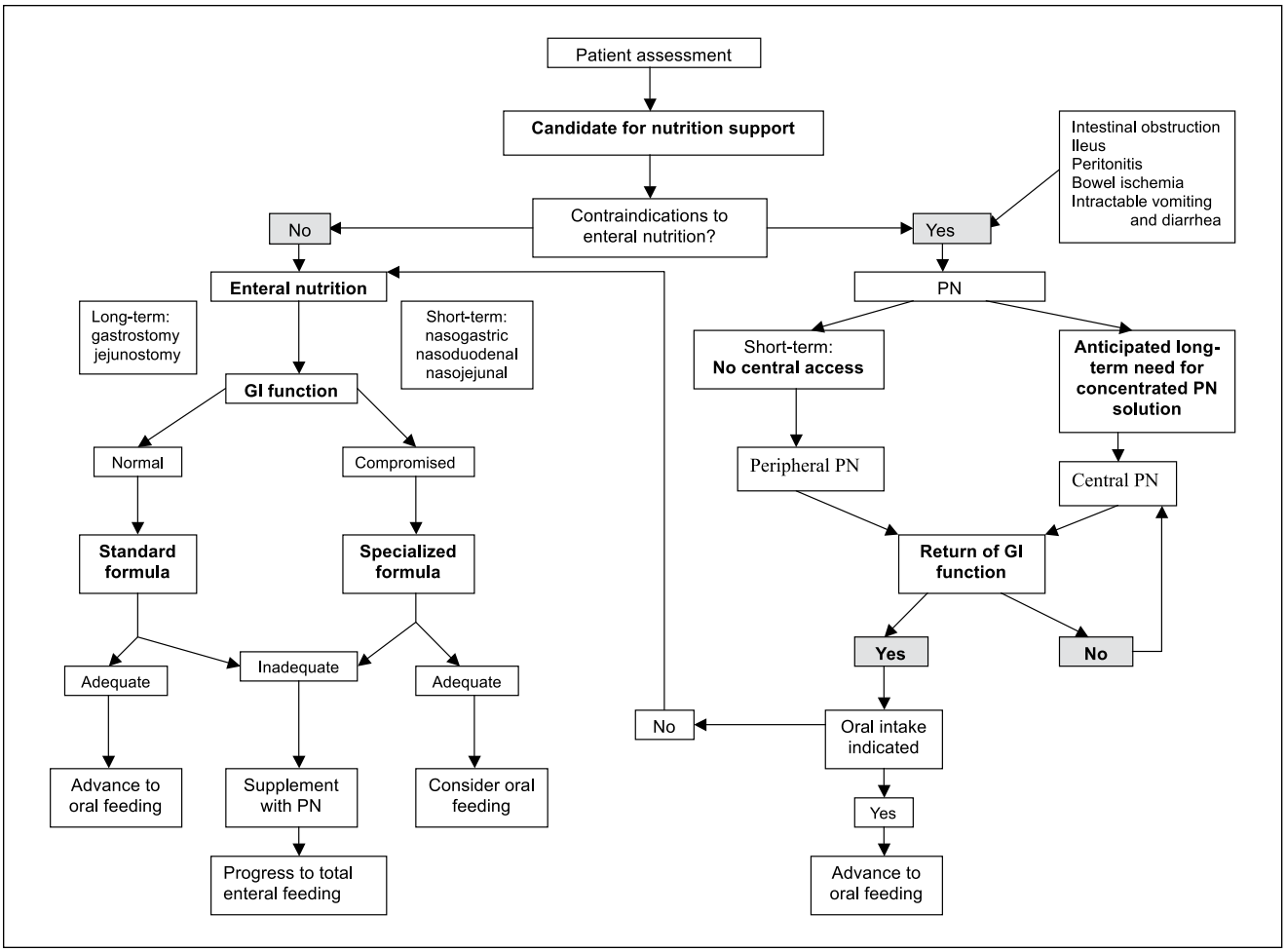

Figure 1. Route of administration algorithm. GI, gastrointestinal; PN, parenteral nutrition. Reprinted from A.S.P.E.N. Board of Directors. *Clinical Pathways and Algorithms for Delivery of Parenteral and Enteral Nutrition Support in Adults*. Silver Spring, MD: American Society for Parenteral and Enteral Nutrition; 1998:4.

members. (In some cases, this review uses the term *client* instead of *patient* to denote the collaborative relationships in the healthcare, medical supply, or political arenas; both terms also infer family members where indicated.) Common themes include issues such as the use of parenteral nutrition (PN) when enteral nutrition (EN) should be trialed more robustly, types of enteral or parenteral access devices and insertion methods, feeding plans, protocols or procedural aspects, and other discussions common to clinical practice.

Professional organizations provide guidance for clinicians in formulating plans of care. The American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) route of administration algorithm (Figure 1) promotes use of the gastrointestinal tract because of its well-recognized physiologic benefit. The algorithm guides the clinician from supplementation of oral intake and use of the gastrointestinal tract before considering the intravenous route, with its increased complexity, risk, and cost to the healthcare system. Enteral formula selection should likewise follow a stepwise progression from the least costly alternative to more specialized formula as clinically indicated by the enteral decision tree (Figure 2) to facilitate Medicare qualification and reimbursement. Reimbursement by third-party payers, including the Centers for Medicare and Medicaid Services (CMS),[6] may depend on stepwise consideration and specific, detailed clinical documentation of consumer-specific scenarios. Deviations from the route of administration algorithm may result in denial of coverage for therapy, in which less invasive and costly forms of nutrition support would have been reimbursed. Ethical principles that underpin the need for use of algorithms and professional standards to guide practice include justice, safety, beneficence (the fundamental obligation to act in the best interest of the patient), advocacy, and nonmaleficence (to reduce risk of harm).

An example of a deviation from the algorithm that one might see in clinical practice involves promotion of jejunal feeding, such as via a gastrojejunostomy tube for potential aspiration

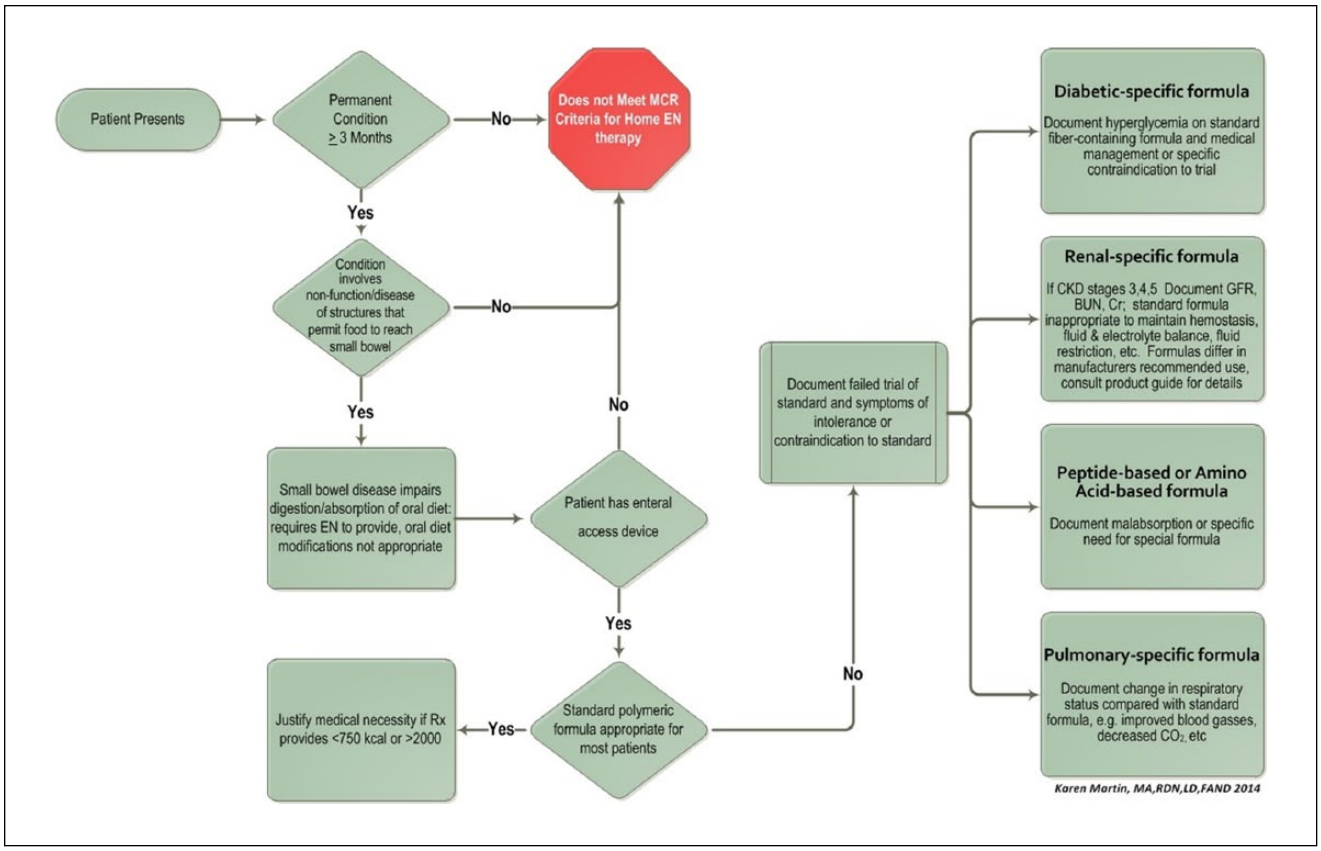

Figure 2. Medicare enteral nutrition decision tree. BUN, blood urea nitrogen; CKD, chronic kidney disease; Cr, creatinine; EN, enteral nutrition; GFR, glomerular filtration rate; MCR, Medicare; Rx, prescription.

when meal-like gastric feeding may suffice and may be preferable to the client if the diagnosis of potential aspiration is related to the swallowing process vs gastric reflux. Time-consuming or complex plans established for a client, such as continuous enteral feeding or another unnecessarily burdensome care regimen, may serve as an injustice when a simpler regimen might allow for more mobility, more time for other activities (family, social, interactive time, etc), or another focus in the client's life. Healthcare team members are morally obligated to establish with (as opposed to for) the client a safe, therapeutic, and effective plan that considers the patient's lifestyle and preferences. Consider a home nutrition regimen in which the intermittent feeding and/or tube flush schedule is ordered for every 4 hours. This regimen would potentially negatively affect quality of life and sleep hygiene of both the client and caregiver. Would this client tolerate gravity feeds during the day instead of repeating a hospital schedule where 24-hour nursing care was available? A meal-type schedule may also have physiologic benefit, especially when return to oral intake may be possible. This is not to say that 24-hour or nocturnal feedings may not be needed for infants and children to meet nutrition and growth goals, but the most simple and least restrictive plan possible should be considered and utilized whenever possible.

The nutrition care plan should consider the client's goals, wishes, lifestyle, and nutrition needs, as well as the client's ability to carry out and pay for the suggested plan. The plan should be established with interdisciplinary input regarding what is feasible and most likely to sustain the client in view of medical conditions and limitations, nutrition needs, tolerance to therapy, and consumer goals. When a peripherally inserted central catheter or a tunneled catheter is inserted for PN that will not be able to be managed adequately and safely and/or paid for because another option might have been possible (eg, use of the small bowel for feeding), the client is exposed to an unnecessary procedure involving risk, healthcare cost, and often increased length of stay in a care facility as well as a delay in implementing another route of therapy. This lack of foreplanning potentially owing to lack of adequate interdisciplinary collaboration could be considered an injustice to the client.

Reimbursement

The trend toward expedited transition from a hospital to home, long-term acute care, a skilled nursing facility, or an acute rehabilitation unit provides a favorable reimbursement scenario for

the hospital. The benefit and efficacy of home nutrition support therapy is well documented and is being used with increased frequency. The rise in EN use is partially related to and can facilitate expedited hospital discharges. Outpatient EN is essential for many clinical conditions in which the diagnosis or sequela from treatment interventions affects the ability to swallow (eg, radiation for head and neck cancer), necessitates temporary alternate feeding routes, or impairs the ability to ingest or absorb nutrients to maintain nutrition status. Such use of EN can reduce complications, lessen readmissions, and may enhance survival. This method of nutrition support might be needed for a 6-week "nothing per os" period, which may be stated in the medical record, in which nasojejunal feeding is needed to allow a pancreatic pseudocyst to mature or an esophageal leak to heal. For example, EN could be needed for several weeks as adjunctive therapy for clients who cannot sustain nutrition status after Whipple surgery until their oral intake increases sufficiently.

The CMS details specific qualifying criteria for home EN and PN therapies.[6] Although certain decisions are made to optimize nutrition status in the hospital, many nutrition care plans are intended to be executed in the home. When this is the case, it is vital that clinicians use resources to optimize consumer care while minimizing consumer cost. When CMS is the payer and consumers rely on reimbursement to utilize nutrition support in the home, the CMS criteria must be met or reimbursement will be denied. Since the early 1980s, Medicare Part B has covered PN and EN under the prosthetic device benefit as a cost-effective alternative to inpatient care. Although it is beyond the scope of this review to detail the criteria for CMS coverage of PN, a PN decision tree and a rubric for supporting documentation have been published.[7-9] Beyond the impact of consumers covered by CMS, the impact extends to other payers (insurers) who follow CMS guidelines for covered vs noncovered therapies.

The above situations lack documentation to meet the CMS "test of permanence" criterion. Although the duration of therapy is not defined in the national coverage determination (NCD),[6] all 4 of the durable medical equipment (DME) Medicare administrative contractors that cover specific U.S. regions define the qualifying length of need as at least 3 months in their local coverage determinations (LCDs). In addition, concern often arises regarding whether EN or PN with CMS as the payer must be provided as the "sole source" nutrition substrate. The CMS NCD language permits reimbursement for therapy if it is required to maintain weight and strength commensurate with the consumer's general condition. Anecdotal reports by various supply providers demonstrate variable interpretation of these requirements, which may result in reimbursement for some but not others with similar situations, potentially affecting fairness, equity, and justice.

The scenarios discussed above clearly result in consumer need for EN; when EN can be provided postdischarge, it may enable earlier discharge and may prevent readmission to a hospital setting for malnutrition and dehydration. Situations like these may present a dilemma for the healthcare provider regarding whether to stretch the truth a bit (ie, document that the pseudocyst could take >3 months to heal, or that the consumer is eating very little after Whipple surgery so that nocturnal feeding via a jejunostomy tube is the primary source of nutrition although it is hoped that oral intake will gradually approach adequacy in the next 1 or 2 months). In these scenarios, healing may suffer and suboptimal nutrition–related adverse effects, possibly including hospital readmission, could occur if reimbursement were denied, which is very likely based on documentation, and the consumer was unable to pay for the therapy. The CMS NCD and LCD documents illuminate the requirements for payment.[6] A lack of specific documentation and qualifying diagnoses and clinical scenarios results in a lack of access to therapy or unexpected out-of-pocket expenses for the home nutrition consumer.

Documentation

Reimbursement may drive documentation, whereas, more appropriately, documentation of clinical need would facilitate reimbursement. Is the "test of permanence,"[10] as defined by the prosthetic device section of CMS that governs nutrition support reimbursement, still a fair criterion in view of the need for continuation of PN or EN for any period of time postdischarge? Clients are discharged more quickly and with more complexity in the current healthcare setting than ever before. Does it matter that the client may depend on EN to sustain nutrition status for 2 weeks or 2 months as opposed to the >3 months defined by CMS to receive reimbursement for this therapy, which may be prohibitive for the client without it? Consider a patient who is receiving PN and is ready for discharge with a fistula, and the patient's physician deems that enteral feeding is inappropriate. This physician is required to forecast when the fistula will heal, which would likely be protracted if the PN were not supplied. Discussions have ensued regarding providers who have admitted to stretching the truth for clients to secure third-party reimbursement for therapy or procedures,[11,12] sharing that "physicians are more willing to sanction deception when the appeals process is longer, the likelihood of a successful appeal is lower, and the health condition is more severe."[13] The desire to serve as a client advocate in this manner can create an ethical challenge or moral dilemma because "lying for consumers may be a violation of federal law."[14] On the basis of results of a self-administered mailed questionnaire survey of 720 physicians, VanGeest et al[15] suggest that decisions to manipulate reimbursement rules for patients (eg, by exaggeration) are a response to system-related issues rather than simply a reflection of individual physician values. Gelpi[16] suggests trying to change the rules of third-party payers and then the game plan or contest between physicians and payers. This can be challenging and may lead to moral distress for providers to be torn between the desire to avoid abuse yet help the client obtain the resources necessary to utilize the required nutrition

care plan. On the other hand, it is the provider's responsibility to society to establish the most cost-effective plan of care that would meet the client's needs.

Many Medicare home providers request documentation specifying that the nutrition therapy is the "sole source" of nutrition; however, it may be the primary source and still meet the guidelines for reimbursement. Honesty in declaring that the consumer is trialing therapeutic feeds with a speech pathologist, that pleasure feedings are allowed, or even that increased oral intake is being encouraged should not affect reimbursement when EN is necessary to maintain nutrition status.

Clients may potentially be exposed to testing for the sake of documentation rather than to gain information that will aid in the treatment plan. Consider a client with bulbar-onset amyotrophic lateral sclerosis with reports of frequent episodes of choking on saliva, foods, and beverages. Given the known progressive nature of the disease and clinical evidence of dysphagia during a chairside examination, it may be prudent to place a gastric feeding device without exposing the client to the risk of aspirating barium and radiation for the sake of documentation. When Medicare is the payer, some infusion companies are reluctant to accept a diagnosis of dysphagia without a fiberoptic endoscopic evaluation of swallowing or a modified barium swallow study. One may document that it is an unsafe or unacceptable risk to obtain a study based on the client's state of consciousness, ability to follow instructions, and so forth. Providers may be driven to order tests that they may deem unnecessary and a disservice to the client in addition to increasing healthcare costs. Although this may be a sign of the times, ongoing consideration should be given to embedded rules and allowances made for individualization based on provider judgement.

Nutrition support clinicians on both sides of the hospital and clinic doors are challenged with documentation requirements and the need to ensure that clients indeed meet reimbursement criteria for nutrition therapy based on third-party payer criteria. Beyond nutrition assessment, care planning, and education, clinicians have entered a realm for which training has been scarce. Professional practice guidelines and standards of care guide the underpinning of clinicians' ethical practice and decision making. Professional organizations such as the Academy of Nutrition and Dietetics,[1] American Nurses Association,[3] American Medical Association,[2] American Society for Health System Pharmacists,[4] and A.S.P.E.N.[17] provide resources such as reference toolkits and codes of ethics to guide clinicians through ethical challenges, including those involving nutrition support practice. Healthcare professionals are increasingly required to test on basics related to jurisprudence and ethics and to obtain educational contact hours for license renewal. Specific training to advocate for nutrition support planning and reimbursement is more likely acquired on the job or through learn-as-you-go training compared with formal preparation. The "see one, do one, teach one" approach does not apply to this subject area, which gets little or no attention in healthcare curriculums that have not focused on guiding consumers in accessing prescribed therapies.

Supply Procurement

After the nutrition delivery plan is established, implemented, and well documented, planning for continuation into the post-discharge setting includes procurement of supplies. Clients may be given EN prescriptions without direction to a home infusion or DME supplier or they may be encouraged to use a provider without consideration for their preferences or best interest, although CMS requires that patients have a choice of providers. The attempt to obtain the formula and delivery through the consumer's pharmacy may be cost prohibitive or the therapy may not be available. Retail pharmacies often fail to direct a consumer to a home infusion or DME provider to supply enteral needs as per Medicare Part B coverage provisions, but they may fill the enteral prescription at a high cost to the consumer. Consumers may obtain formula products from a retailer, which may not be comparable to what was prescribed to meet specific nutrition needs. Furthermore, related products to facilitate delivery, site care, and monitoring of therapy may not be available and reimbursement will not be solicited on the consumer's behalf. Liquid supplements intended for oral use may not meet dietary reference intake levels for long-term use and costs can add up for these noncovered products. A consumer who does not meet Medicare guidelines or whose insurance does not cover formula may find lower prices through a retailer, rather than obtain the product through an infusion or DME supplier. Nutrition prescribers may be unaware that their nutrition orders are not executed after the consumer leaves the hospital or clinic setting, and they may learn several months later that the nutrition therapy was not implemented as a result of confounding factors. Clinical documentation or lack thereof can make or break the case for third-party payer coverage.

The National Home Infusion Association (NHIA) provides an ethics toolkit[18] and standards[19] designed to optimize consumer and caregiver rights and safety and to ensure appropriate collaboration with referral sources, manufacturers, and business affiliates as well as compliance with oversight to eliminate fraud, waste, and abuse. Members voluntarily attest to accepting the general tenets of the NHIA Standards for Ethical Practice in guiding the members' clinical practices and business operations. The market is replete with less than scrupulous practices, including situations in which an infusion company hires a family member to be a "consumer advocate" related to a particular therapy, thus garnering the infusion business for the family member's relative or child. This is not to cast general suspicion toward consumer advocacy programs, because they can be very valuable in terms of education, peer support, and mentoring; however, when high-dollar therapies enter the "pay to play" arena by those espousing the ethical tenets of NHIA, it is cause for concern and may deserve further scrutiny.

Other ethical issues that might relate to the supply arena include enticements for referrals (eg, gifts, sporting event tickets, or other favors offered to potential referral sources) and competition between suppliers for consumer business that may overlook the consumer's best interest. The referring agency is morally and ethically responsible for assisting in referring a consumer to the home medical supplier who can best meet the consumer's preference and needs, including needs for ongoing follow-up by appropriate professional staff, as opposed to simply dispensing product. Another ethical indiscretion may occur when infusion providers are hesitant to wean consumers and promote transitional feeding because CMS funding may be at stake, such as when the therapy is not needed daily yet the natural process of weaning is more appropriate than an "all-or-nothing" approach and promotes EN availability as a backup until adequacy of and tolerance to oral intake is well established. Many home PN consumers could decrease the number of infusions per week and use only hydration, yet hydration is not covered by Medicare and is thus an out-of-pocket expense. In addition, as PN is being weaned, reimbursement is at risk when the consumer is less dependant on the therapy yet is unable to be maintained on an oral diet or EN.

Home Care

Florence Nightingale had a futuristic vision of home healthcare as shared in her 1867 writings to Henry Bonham Carter.[20] She aimed for the direction of caring for people in their homes, and today we know the prudence of home care for many reasons, including fiscal prudence and infection control. Nightingale stated, "My view you know is that the ultimate destination is the nursing of the sick in their own homes.… I look forward to the abolition of all hospitals and workhouse infirmaries. But it is no use to talk about the year 2000."[20] Reimbursement must be available to enable clients to remain in their homes. Resource shifting may need to be considered to enable this transition from hospital to home.

When nutrition therapy is not reimbursable by CMS or other payer criteria, consumers bear the financial responsibility and may be asked to provide payment up front, which may tax the family budget. Lack of reimbursement may preclude the consumer from receiving needed nutrition support. Increasingly, private insurance policies exclude formula coverage, noting that everyone has to pay for "food," but may cover pumps and supplies. Most family food budgets do not exceed the Center for Nutrition Policy and Promotion of the U.S. Department of Agriculture's (USDA) Liberal Food Plans[21] (the USDA's Low-Cost, Moderate-Cost, and Liberal Food Plans each represent nutritious diets at different cost levels to aid consumers matching nutritious food procurement with different budgets) and would be stressed by adding the costs of purchasing specialized nutrition support products. Although Medicare pays 80% of covered charges, the remaining 20% is the consumer's responsibility if there is no secondary insurance, which can lead to a significant financial burden. The rules of CMS programs do not allow suppliers of DME, prosthetics, orthotics, and supplies to waive copayments, deductibles, or other owed amounts that are the consumer's responsibility except on a case-by-case basis on determination of financial need. Home care and infusion providers should consider the consumer's out-of-pocket expenses regarding use of out-of-network benefits. Often, an out-of-network provider will serve a consumer when an in-network provider could offer the same therapy while minimizing the consumer's out-of-pocket costs. Conflicts of interest, fidelity (truthfulness in relationships), integrity, and altruism (selfless concern for the well-being of others) could be involved in similar situations.

Several consumer assistance programs affiliated with formula manufacturers may provide formula for individuals meeting financial and use criteria, such as income as a percentage of the poverty level and EN required as "sole-source" nutrition. This assistance is more likely to be available earlier in the year, because program resources may be exhausted later in the year. The Oley Foundation[22] equipment exchange provides a resource list in which those who need EN formula and supplies can connect with donors who have supplies. The recipient is responsible for shipping costs, so it is wise for consumers to comparison shop when considering shipping costs vs prices for local or Internet purchases.

Another alternative for EN consumers who do not qualify for reimbursement for commercial formulas, or simply elect the option, is home-blended feedings where the home environment and caregiver situation is appropriate.[23] When consumers are satisfied with a more time-consuming method of administration of nutrition via an enteral tube such as this, it may be a useful option. However, the plan should include both education regarding preparation and administration methods to ensure quality and safety and ongoing monitoring of adequacy and problem prevention/detection. A question of fairness might be raised: why do some qualify for reimbursement and not others?

Some have raised concern regarding oversupply of resources, formula, flushes, dressing change kits, and so forth as potential abuse. Medicare requires refill calls or written requests for EN and PN consumers and denies products that are automatically shipped. The contracted provider must document the quantity the beneficiary has on hand, and they must list who is requesting the refill. The request and delivery must not occur sooner than the date specified by CMS and the delivery ticket must be available. The infusion provider is not reimbursed for additional items sent; in fact, many items provided (eg, low-profile gastric devices and extension sets) may not be reimbursed by CMS at a rate that approaches the cost to the supplier. Monthly billing and supply provision including shipping help curtail home supplier cost but may lead to excess supplies for consumers, especially if the need for a product change is identified before the current product supply is exhausted.

Consumers who have excess supplies feel guilty throwing them out, yet they may not be comfortable sharing them online.

Many express a sense of giving back and completing therapy in finding someone to which they can "pay it forward." It can be gratifying to find a recipient for an unused case of feeding product (nourishment) or other supplies, especially for someone in need, who may be beginning the journey and for whom reimbursement status may be tenuous or denied. Local exchanges would be very beneficial for parties needing supplies as well as those with supplies they no longer need, provided someone is willing and able to facilitate a charitable cause such as this.

Monitoring and Follow-Up

Monitoring and follow-up of consumers requiring EN in the home setting by qualified and competent professionals not only enhances safety and efficacy of therapy, it can also help reduce complications, including potential for refeeding syndrome and others that may lead to readmissions.[24,25] It is also important to watch for changes in the consumer's condition, which may signal potential to trial less aggressive therapy (eg, the ability to begin oral intake and wean from EN as the client regains strength). Monitoring and follow-up can be driven by reimbursement, instead of need driving reimbursement. Guidelines for reimbursement for follow-up in the home setting also limit access to this critical aspect of care related to EN. Some home medical suppliers employ registered dietitians and registered nurses to monitor consumer progress. Physician reimbursement for managing patients who receive home nutrition support is very limited or nonexistent, yet many patients have complex issues including electrolyte derangements that require close monitoring and management.[26] Other clients may be monitored and followed by professionals in provider clinics, yet some may be only provided a number to call if they have questions or concerns, provided they can articulate that they are indeed experiencing a problem, concern, or lack of progress. Clients who require EN, those who manage EN themselves, or others might be given a rigid plan of how EN must be administered. Instead of viewing and labeling an individual as "noncompliant," the promotion of a collaborative or concordant relationship (in which decisions are made collaboratively) that respects patient autonomy may not only enhance the working relationship, but it may also reduce moral distress that can result from an authoritative professional approach. These issues may involve justice, fidelity, altruism, and beneficence.

Political Aspects Related to EN and Reimbursement

States vary in their statutes and regulations regarding coverage of medical nutrition products. For example, coverage for metabolic disorders identified through newborn screening may vary from state to state. Although a state may mandate coverage by private insurers for metabolic formulas, the coverage benefit may not approximate the product cost. Consider an example in which the wholesale cost for monthly nutrition products for an inborn error of metabolism was >$798 and the reimbursement was $70 based on the "coverage" calculated at the standard polymeric formula reimbursement on a per-100-calorie basis. The insurer met the coverage criteria for the state's requirement regarding group health benefit plans, but not at a level that allowed the consumer to access the therapy for vital nutrition to avoid mental or physical retardation. Fortunately, the state had an assistance program with more robust coverage for these individuals in this "catch 22" situation.

The authors posit a best practice to minimize risk, discomfort, and excess cost and facilitate implementation of the home nutrition care plan: verify that the consumer qualifies for therapy and consider financial resources to fund the therapy before placing a vascular or EN access device. The best nutrition care plan is futile if there are no resources to implement it. The access placement procedures are not without risk. Case managers and nutrition support clinicians within the hospital may consult with home infusion specialists to clarify coverage based on clinical documentation and a consumer's history, diagnosis, and anticipated course of treatment. Often, vascular access devices are scheduled and placed for home PN or enteral tubes are placed for home enteral therapy when consumers' diagnosis and scenario do not meet the guidelines for coverage and consumers and their families lack the physical and financial resources to prepare or fund the therapy. Medicare reimbursement for tube placement varies depending on the placement site (doctor's office, facility, hospital outpatient department, or ambulatory surgical center), tube type/site (gastrostomy, jejunostomy, or gastrojejunostomy), and placement method (fluoroscopic or endoscopic guidance, or laparoscopic placement). Current physician reimbursement per Medicare payment rates ranges from $218 to $591 and facility reimbursement ranges from $591 to $1185. When consumers require home nursing support for access device use and care to monitor nutrition therapy, a 60-day episode of nursing care reimbursement varies by location but can range from $2300 to $3000.

Although evidence-based practice is the benchmark for the practice of nutrition support, some current Medicare guidelines utilize outdated criteria relative to best evidence. The current CMS "NCD for Enteral and Parenteral Nutritional Therapy" shows little change from the original 1984 document to incorporate current evidence.[6] Consider the utility of the serum albumin level as an indicator of visceral protein status.[27] Several PN situational qualifiers (E, F, and G/H) still use a serum albumin level ≤3.4 g/dL as an indicator of visceral protein status. Although the serum albumin level was once the gold standard for documenting the status of visceral proteins, current evidence indicates that stressed consumers' serum albumin levels are labile as negative acute-phase reactants and vary with fluid status, inflammation, and stress.[9] Furthermore, clinicians are able to diagnose severe malabsorption (situation E) by means other than fecal fat testing, which remains in the Medicare coverage determination. Other indicators such as

D-xylose absorption test results, fat-soluble vitamin deficiencies, uncontrollable steatorrhea, or undigested food in the ostomy or stool could substantiate malabsorption without subjecting an ill patient to dietary fat intake of 100 g/d and collecting and refrigerating stool for a 72-hour period.

Government reimbursement for home EN has been shown to reduce rates of malnutrition, as demonstrated by Klek et al in a study of several European countries.[25] Utilizing data gathered via the Nutrition Day Project, a reduction in malnutrition and related consequences was identified in European countries where the government sponsored "artificial" nutrition delivered by a home infusion provider, with education and monitoring by team members during routine visits for those who had previously received blenderized food and no formal monitoring.[25] It seems prudent for nutrition support clinicians to support and advocate for re-evaluation of the current U.S. system established >30 years ago. Providers and consumers surveyed by the A.S.P.E.N. Public Policy Committee in 2015[17] reported reduced access to nutrition care because of changes in insurance coverage related to national healthcare policy changes. The potential benefit of retooling guidelines based on research and best evidence could significantly affect consumer care.

There is a need to demonstrate value and outcomes[26] including both quantitative and qualitative research related to quality-of-life issues, and health economics and outcomes research can be used to guide research to support value, return on investment, and reimbursement decisions.[28] To support this effort, nutrition support clinicians should contribute to data collection (eg, via Nutrition Day, which provided data for the assessment performed by Klek et al[25] on nutrition status in several European countries). Practitioners are encouraged to take an active role in ethics committees and engage in discussions in their work settings, local areas, and even in the national political arena by serving as advocates regarding nutrition support decisions. The A.S.P.E.N. Public Policy Committee has identified supporting reimbursement for nutrition therapy and appropriate clinician services to improve consumer care as a priority initiative in its current vision and mission statement.[17] This is an important priority that should be espoused by nutrition support clinicians, as reflected in this discussion.

Clinical understanding may be lacking or underappreciated in the judicial process. This may be expanded to the political arena, where healthcare professionals must play a role in helping legal experts and politicians understand the complexity involved in addressing the human aspects of healthcare. Healthcare professionals must be involved in the political process as decisions are made on behalf of the healthcare consumer. Their role is to temper what may be perceived by politicians as a "black and white" world to the "gray" nature that is often the reality of the healthcare arena. Rigid rules may put providers in a catch 22–type situation, in which they are caught between the desire to serve as consumer advocates while maintaining professional integrity. Rules and regulations that may once have seemed logical or helpful for clinical situations may now need to be challenged to meet the reality of today's healthcare arena.

Summary

Because EN is being used with increasing frequency in the home care setting and this permits clients to be discharged from acute care settings earlier, the longstanding rules for reimbursement should be re-evaluated. Nightingale's vision >150 years ago of consumers remaining in the home is consistent with current national healthcare initiatives, and efforts to support the safety and cost-effectiveness of this therapy should be encouraged. The cost of EN may not be overwhelming compared with many other therapies, but this cost can be substantial for many consumers whose health depends on being able to pay for needed nutrition products and related supplies for the duration of need. Ethical challenges can face the provider tasked with establishing the ongoing nutrition support plan, including administration, supply procurement, follow-up, monitoring, and plan revision. Provider use of deception to secure third-party payer approval of medically indicated care "may reflect a tension between the traditional ethic[s] of consumer advocacy" and the ethics of cost control in the arena of limited resources,[11] resulting in moral dilemmas and ethical challenges. It is imperative that providers utilize solid evidence and sound principles in establishing the nutrition support plan as well as exercising fiscal responsibility, including social justice appropriately balanced with consumer advocacy.

Statement of Authorship

K. Martin and C. McGinnis equally contributed to the conception and design of the review article and the literature review. K. Martin solely created the enteral nutrition decision tree. K. Martin and C. McGinnis drafted the manuscript, critically revised the manuscript, agree to be fully accountable for ensuring the integrity and accuracy of the work, and read and approved the final manuscript.

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