MetroPlus Health

Policy and Procedure

Title: Intradialytic Parental Nutrition (IDPN)	Division: Medical Management Department: Utilization Management
Approval Date: 10/3/2022	LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, GoldCare I&II, Market Plus, Essential, HARP, UltraCare
Effective Date: 10/3/2022	Policy Number: UM-MP341
Review Date: 9/24/25	Cross Reference Number:
Retired Date:	Page 1 of 6

1. POLICY DESCRIPTION:

This policy outlines the criteria for Intradialytic Parental Nutrition.

Effective 4/1/2023, NYS Medicaid members enrolled in mainstream Medicaid Managed Care (MMC) Plans, Health and Recovery (HARP) Plans, and HIV-Special Needs Plans (HIV-SNP) will receive their pharmacy (and certain DME supplies) benefits through the NYRx Pharmacy program (previously known as Medicaid FFS) instead of through MetroPlus Health Plan. Within the Durable Medical Equipment, Prosthetics, Orthotics, Supplies and Procedure Codes and Coverage Guidelines, sections 4.1, 4.2, and 4.3 are subject to the transition while sections 4.4, 4.5, 4.6, and 4.7 will remain the responsibility of MetroPlus Health Plans.

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:

Intradialytic parenteral nutrition (IDPN) - involves infusion of dextrose, amino acids, and/or lipids during hemodialysis or peritoneal dialysis sessions through the venous dialysis drip chamber. During hemodialysis, the IDPN infusion is administered through the venous port of the dialysis tubing, typically, 30 minutes after dialysis has begun, and continued throughout the remainder of a dialysis session. In peritoneal dialysis, parenteral nutrition is infused into the peritoneal cavity during peritoneal dialysis.

4. POLICY:

MetroPlus requires prior authorization for IDPN.

IDPN is considered medically necessary for a patient who is currently receiving dialysis for End Stage Renal Disease when one of the following criteria is met:

A. Protein caloric malnutrition with **all** of the following:
   a. The patient has completed a stepwise approach to treatment, beginning with dietary counseling and diet modifications, followed by oral nutritional supplements, and then enteral nutrition supplements.
   b. The patient has a serum albumin less than 3.2 g/dl or a prealbumin less than 30 mg/dl

c. The patient has an adequate dialysis prescription (single pool KT/V of at least 1.25) and their acidosis has been corrected (serum tC02 of greater than or equal to 22 mmol/l)
d. The patient cannot tolerate full nutrition with an oral supplement, but can consume at least 50% of their necessary caloric and protein intake (e.g. diabetic gastroparesis)
e. A non-edematous or post-dialysis documented loss of body weight greater than 10 % over a 3- month period

B. Patients who cannot tolerate oral/enteral feedings and **one of the criteria is met**:
   a. A condition which requires the gastrointestinal tract to be totally non-functioning for a period of time;
   b. Evidence of structural or functional bowel disease making oral and tube feedings inappropriate.
   c. Patient is peri-operative (regardless of disease state) and unable to tolerate oral or tube feedings.
C. Hyperemesis gravidarum, only in cases of failed medical management or when used in a step-therapy program;

The initial approval will be for 3 months. Reevaluation is required to determine the continued need after 3 months of IDPN.

5. LIMITATIONS/ EXCLUSIONS:

Parental nutrition is not considered medically necessary for patients with a functioning gastrointestinal tract whose need for parental nutrition is only due to:

a. A physical disorder impairing food intake such as the dyspnea of severe pulmonary or cardiac disease;
b. A psychological disorder impairing food intake such as depression;
c. A side effect of a medication;
d. A swallowing disorder;
e. A temporary defect in gastric emptying such as a metabolic or electrolyte disorder;
f. Disorders inducing anorexia such as cancer;
g. Renal failure and/or dialysis (For patients to receive IDPN, they must meet the criteria for total parenteral nutrition, as noted in this Policy)

Intradialytic parenteral nutrition is considered not medically necessary when offered in addition to regularly scheduled infusions of Total Parental Nutrition (TPN). TPN is the appropriate

therapy and IDPN is considered investigational as a single therapy in patients who cannot tolerate any oral/ enteral feedings.

6. APPLICABLE PROCEDURE CODES:

CPT	Description
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) home mix
B4168	Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) home mix
B4172	Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) home mix
B4176	Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) home mix
B4178	Parenteral nutrition solution: amino acid, greater than 8.5% (500 ml = 1 unit) home mix
B4180	Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) home mix
B4185	Parenteral nutrition solution, not otherwise specified, 10 grams lipids
B4189	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein premix
B4193	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein premix
B4197	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein premix

B4199	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein premix
B4216	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes), home mix, per day
B4220	Parenteral nutrition supply kit; premix, per day
B4222	Parenteral nutrition supply kit; home mix, per day
B4224	Parenteral nutrition administration kit, per day
B5000	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal aminosyn rf, nephramine, renamine premix
B5100	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine premix
B5200	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress branch chain amino acids freamine hbc premix

7. APPLICABLE DIAGNOSIS CODES:

CODE	Description
N18	Chronic Kidney Disease
N18.5	Chronic Kidney Disease, Stage 5
N18.9	Chronic Kidney Disease, unspecified
N19	Unspecified kidney failure

8. REFERENCES:

Foulks CJ. An evidence-based evaluation of intradialytic parenteral nutrition. Am J Kidney Dis. 1999;33(1):186-192.

Hotta SS. Intradialytic parenteral nutrition for hemodialysis patients. Health Technology Review No. 6. AHCPR Pub. No. 93-0068. Rockville, MD: Agency for Health Care Research and Quality (AHRQ); August 1993:4.

Wegrzyniak LJ, Repke JT, Ural ST. Treatment of Hyperemesis Gravidarum, 2012; 5(2): 78–84 [PubMed] [Google Scholar]
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3410506/

UpToDate - Pathogenesis and treatment of malnutrition in maintenance hemodialysis patients. Literature review current through:August 2025.
https://www.uptodate.com/contents/pathogenesis-and-treatment-of-malnutrition-in-patients-on-maintenance-hemodialysis?search=idpn&source=search_result&selectedTitle=1%7E3&usage_type=default&display_rank=1#H16

REVISION LOG:

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Approved:	Date:	Approved:	Date:
David Ackman Digitally signed by David Ackman Date: 2025.09.30 13:51:55 -04'00'		Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2025.09.30 16:09:45 -04'00'	
David Ackman, MD **VP of Medical Director**		**Sanjiv Shah, MD** **Chief Medical Officer**	

Medical Guideline Disclaimer:

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 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government, or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication. MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.