

Caring for the Ages

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Nursing Home Parenteral Therapies: Clinical Guidance and Payment Considerations

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The most fundamental principle in geriatric and long-term care medicine: ensure every treatment order aligns with the resident's values and goals of care—eliciting these is a core skill for long-term care physicians. Many residents have multimorbidity, and a substantial proportion are at the end of life. Ethical frameworks for artificial nutrition and hydration reinforce this goals-concordant approach.¹

A new tension has arisen in the nursing home because of additional and significant payment for parenteral IV feeding and medication under PDPM. The non-therapy ancillary component has IV treatment valued between 3 and 7 points out of a possible 12, depending on intensity. For comparison, malnutrition, feeding tubes, and morbid obesity are worth one point.

If a patient is prescribed an IV medication, it's worth five points. IV or parenteral fluid can change the nursing care contribution to PDPM to a Special Care High if they have a function score of 14 or lower. That means they are not the most dependent for ADL residents. This can be coded for IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently; IV fluids running at KVO (keep vein open); IV fluids contained in IV piggybacks; hypodermoclysis and subcutaneous ports in hydration therapy; IV fluids can be coded if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated, and supporting documentation should be provided in the medical record. IV medications are categorized as clinically complex nursing care.

Thus, parenteral fluids and/or medications will increase the nursing home's compensation during a Medicare Part A stay. There are many states converting Medicaid payment models from RUG to PDPM, too, so incentives for parenteral treatments can extend from Part A stays to long-term care patients as well.²

As long-term care medical providers, our first responsibility is to our patients. We also want the nursing homes where we see our patients to be financially viable. How should this payment model affect our treatment decisions?

In some cases, PDPM incentives for IV treatments have enabled earlier transitions from hospital to nursing homes, where facilities can compensate skilled nurses to administer these treatments. Many nursing homes are expanding their scope of service to include monoclonal antibodies for COVID-19, partly due to administrative fees and compensation models.

However, as seen with aggressive rehabilitation at the end of life, payment incentives can drive parenteral fluids and medications for residents for whom such treatments are not goal-concordant. Ethical guidance emphasizes aligning artificial nutrition and hydration with the resident's stated values and goals.¹

A review of the literature revealed no evidence supporting the preventive use of parenteral hydration or nutrition, defined as administering treatment solely for risk factors of dehydration or malnutrition without clinical evidence of either. Conversely, parenteral hydration remains appropriate for many acute conditions; for instance, IV fluids are central to the management of sepsis and acute dehydration when clinically indicated. Evidence and expert reviews underscore the importance of accurate diagnosis and appropriate management rather than prophylactic parenteral therapy.^{4,5,1}

Access to IV medications in a rehabilitation setting can provide an effective balance between treatment and recovery, particularly when delivered by trained nursing home staff—an approach associated with reduced hospital admissions in pragmatic trials.⁶

Determining whether parenteral therapy is appropriate for a nursing-home resident requires careful clinical judgment and shared decision-making. Ideally, this includes a discussion with the resident or their decision-maker to establish individualized care goals and the acceptability of life-prolonging treatment. If such treatment is desired, clinicians must consider:

- Whether parenteral therapy aligns with the resident's expressed preferences
- Whether less invasive alternatives (such as oral hydration) are feasible
- The expected clinical benefit and time-to-benefit
- The resident's ability to tolerate the intervention

These considerations are central to ethical practice around artificially administered nutrition and hydration.¹

When hydration is indicated, route matters. Subcutaneous hydration (hypodermoclysis) is a viable alternative in older adults and may have different adverse-effect profiles compared to IV hydration; randomized data inform risk–benefit discussions.⁷ Broader reviews of hydration interventions in facilities can guide non-parenteral strategies (e.g., structured oral hydration support).^{3,4} For nutritional concerns, consider evidence-based oral strategies (e.g., micronutrient supplementation) before escalating to parenteral nutrition when goals and clinical status allow.⁸

Given these necessary steps, protocols that encourage an arbitrary number of residents to receive parenteral treatment each week are not medically justified. Requests for preventive parenteral hydration or nutrition are more likely driven by facility-level financial incentives than by individual resident needs. Payment and quality-reporting changes under PDPM/CMI can create pressure, but clinical decisions should remain individualized and evidence-based.^{2,1}

Nursing home medical providers may face pressure from facilities and vendor companies to use parenteral treatments. Vendors may offer theoretical benefits for ordering parenteral treatments “wisely.” Providers can stand confidently on the position that all medical treatments must be consistent with the patient’s individual clinical circumstances and goals—and that is the standard to which they will adhere.¹

Citations

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