Home Continuous Inotropic Infusion Therapy

I. *Policy*

University Health Alliance (UHA) will reimburse for home continuous inotropic infusion therapy when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. *Criteria/Guidelines*

A. Home continuous inotropic infusion therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:

1. Clear goals of care have been established with shared decision-making.
2. The patient is in the process of being evaluated for or is awaiting mechanical circulatory support or cardiac transplantation; or patient has end stage heart failure (Stage D or NYHA Class IV heart failure prior to inotropic therapy use) and such therapy would allow them to spend their remaining days in greater comfort.
3. The patient has symptoms of continuing congestive heart failure (e.g., dyspnea at rest) despite maximal medical therapy, such as treatment with maximum or near maximum tolerated doses of loop diuretic, spironolactone, beta-blocker and angiotensin-converting enzyme inhibitor, or another vasodilator used simultaneously (unless patient is allergic or intolerant).
4. The doses are within the following ranges. Lower doses are covered only as part of a weaning or tapering protocol from a higher dose level.
    a. Dobutamine 2.5-10 mcg/kg/min
    b. Dopamine 2-5 mcg/kg/min
    c. Milrinone 0.375-0.750 mcg/kg/min
5. The patient must be maintained on the lowest practical drug dose and efforts to decrease the dose or the frequency/duration of the infusion are documented during the first three months of therapy.
6. Hemodynamic studies (which may include inpatient bioimpedance studies) performed within six months prior to initiation of home therapy demonstrating both of the following:
    a. Cardiac index less than or equal to 2.2 liters/min/meter square and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotropic infusion on maximum medical management.
    b. Increase in cardiac index of at least 20 percent and/or decrease in PCWP at least 20 percent during inotropic infusion at the dose initially prescribed for home infusion.
7. The patient's condition is stable at the time of inpatient discharge with documentation of a positive response to inpatient inotropic therapy (e.g., absence of dyspnea at rest, stable cardiac symptoms, vital signs, weight, and laboratory values).
8. There is documentation of deterioration in clinical status when the drug(s) is tapered or has been discontinued under observation in the hospital.
9. The patient does not require routine electrocardiographic monitoring at home.

10. The patient is capable of maintaining at least monthly physician follow-up evaluations to assess and document the patient's cardiac symptoms, vital signs, weight, laboratory values, and response to therapy.
11. Patient must be homebound.
12. All reversible impediments to independence from inotropic infusion therapy have been or are being addressed, including dieting compliance.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. *Limitations/Exclusions*

A. Home continuous inotropic infusion therapy is not covered when:
    1. The patient or caregiver is unwilling or unable to manage or continue with the home infusion program.
    2. The patient or caregiver is noncompliant with treatment and follow-up with the prescribing physician.
    3. Evaluation of clinical data, tests, and symptoms indicate that continuous inotropic infusion therapy is no longer required or effective.
    4. The patient can be weaned from continuous inotropic infusion therapy and is responsive to standard oral medications.
B. Hospitalization is indicated for an unstable patient with significant arrhythmias and/or other medical complications requiring acute care and treatment
C. Intermittent inotropic infusion therapy is not covered as it has not been shown to improve health outcomes.

IV. *Administrative Guidelines*

A. Prior authorization is not required.
B. The home therapy provider is responsible for obtaining and maintaining the appropriate documentation of medical necessity as outlined above in the criteria and guidelines.
C. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made.

V. *Policy History*

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