I. Description

Heart failure is an incapacitating and increasingly common cause of cardiac morbidity and mortality. Parenteral inotropic agents may be beneficial in hospitalized patients awaiting cardiac transplantation who cannot be weaned from inotropic therapy. Treatment can be effectively managed on an outpatient basis following positive response to an inpatient trial of inotropic infusion therapy.

II. Criteria/Guidelines

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

1. The patient is in the process of being evaluated for or is awaiting cardiac transplantation.
2. The patient has symptoms of continuing congestive heart failure (e.g., dyspnea at rest) despite 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).
3. 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. Amrinone (Inamrinone) 5-10 mcg/kg/min
   d. Milrinone 0.375-0.750 mcg/kg/min
4. 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.
5. Hemodynamic studies (which may include inpatient bioimpedance studies) performed within six months prior to initiation of home therapy demonstrating both of the following:
Home Inotropic Infusion Therapy

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.

6. The patient’s condition is stable at the time of 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.)

7. For intermittent infusions, there is documentation of repeated hospitalizations for congestive heart failure despite maximum medical management. For continuous infusion, there is documentation of deterioration in clinical status when the drug(s) is tapered or has been discontinued under observation in the hospital.

8. The patient does not require routine electrocardiographic monitoring at home.

9. 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.

10. Patient must meet the definition of homebound found in the Glossary to receive this service.

III. Limitations/Exclusions

A. Home inotropic 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 inotropic infusion therapy is no longer required or effective.
   4. The patient can be weaned from inotropic infusion therapy and is responsive to standard oral medications.
   5. Hospitalization is indicated for an unstable patient with significant arrhythmias and/or other medical complications requiring acute care and treatment.

IV. Administrative Guidelines

A. Precertification is not required. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

B. For administrative information, including billing instructions, examples and code information, see Home Inotropic Infusion Therapy - Administrative Information.

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to
discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References


