

MEDICARE INOTROPIC QUALIFICATION CHECKLIST

Core Coverage Criteria:

ALL OF THE FOLLOWING CRITERIA MUST BE MET FOR COVERAGE

1. Dyspnea at rest despite treatment with maximum or near maximum tolerated doses of Digoxin, a loop diuretic and angiotensin converting enzyme inhibitor or another vasodilator used simultaneously (unless allergic or intolerant.) Yes _____ No _____
2. Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher doses.
 - a) Dobutamine 2.5 – 10 mcg/kg/min
 - b) Milrinone 0.375 – 0.750 mcg/kg/min
 - c) Dopamine <2 mcg/kg/minYes _____ No _____
3. Invasive hemodynamic studies performed within 6 months prior to the initiation of home inotropic therapy show:
 - a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter squared **and/or** pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mmHg **before** inotropic infusion on maximum medical management. Yes _____ No _____
 - b) at least a 20% increase in CI **and/or** at least a 20% decrease in PCWP during inotropic infusion at the dose initially prescribed for home therapy. Yes _____ No _____
4. An improvement in patient well being (less dyspnea, improved diuresis and improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing MD at least monthly. Yes _____ No _____
5. If continuous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in a hospital. Yes _____ No _____
6. Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine EKG monitoring at home. Yes _____ No _____
7. The patient is maintained on the lowest practical dose and efforts to decrease the dose of the drug(s) or the frequency/duration of infusion are documented during the first 3 months of therapy. Yes _____ No _____
8. The patients cardiac symptoms, vital signs, weight, lab values and response to therapy are routinely assessed and documented in the patient's medical record. Yes _____ No _____

Home Parenteral Inotropic Therapy: Data Collection Form

Patient's name: _____ HIC # _____

Information below may not be completed by the supplier nor anyone in a financial relationship with the supplier.

- 1) Results of invasive hemodynamic monitoring:

	<u>Cardiac Index</u>	<u>Wedge Pressure</u>	<u>Date</u>
Before inotrope infusion	_____	_____	_____
On inotrope infusion	_____	_____	_____
Drug _____		Dose _____	mcg/kg/min

- 2) Cardiac medications (digoxin, diuretics, vasodilators) immediately prior to inotrope infusion (list name, dose, frequency): _____

- 3) Does this represent maximum tolerated doses of these medications? _____

4) Breathing status (check one <u>in each column</u>)	<u>Prior to inotrope infusion</u>	<u>At time of discharge</u>
No dyspnea on exertion	_____	_____
Dyspnea on moderate exertion	_____	_____
Dyspnea on mild exertion	_____	_____
Dyspnea at rest	_____	_____

- 5) Initial home prescription: Drug: _____ mcg/kg/min
_____ hrs/day _____ day/week (or every _____ days)

- 6) If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed? _____
- 7) If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which Parenteral inotropes were required? _____
- 8) Is the patient capable of going to the physician for outpatient evaluation? _____
- 9) Is routine electrocardiographic monitoring required in the home? _____

The above statements and an additional explanations included separately are true and accurate and there is documentation present in the patient's medical record to support these statements.

Physician Signature: _____ Date: _____

Physician Name Printed / Typed: _____ UPIN # _____

Physician Specialty: _____
