



Arkansas Department of Human Services

Division of Medical Services

Donaghey Plaza South
PO Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone: (501) 682-8292 TDD: (501) 682-6789 or 1-877-708-8191 FAX: (501) 682-1197

OFFICIAL NOTICE

DMS-2003-J-1

TO: Health Care Provider – Prosthetics

DATE:

SUBJECT: Criteria for Use of External Infusion Pump (Mechanical, Reusable)

I. Introduction

Effective August 1, 2003, Arkansas Medicaid is revising the criteria for the use of the external infusion pump (mechanical, reusable) to assist providers in determining when a pump may be covered. Information regarding covered medical supplies and requirements for prior-authorization for use of the pump and for the medical supplies are also included in this notice.

Medicaid only pays for one pump; the supplier is responsible for ensuring that there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment.

Note: A second pump provided as a backup will be denied as not medically necessary.

II. Conditions of Coverage

External infusion pumps are covered in the following situations.

- A. To administer deferoxamine for the treatment of chronic iron overload.
- B. To administer chemotherapy drugs for the treatment of primary hepatocellular carcinoma or colorectal cancer when the disease is unresectable or the patient refuses surgical removal of the tumor.
- C. To administer morphine for the treatment of intractable pain caused by cancer.
- D. Administration of other drugs when either of the following two sets of criteria are met.

III. Criteria for Coverage for the Administration of Other Drugs

A. Criteria Set One:

1. Parenteral administration of the drug in the home is medically necessary.
2. An infusion pump is necessary to safely administer the drug.
3. The drug is administered by a prolonged infusion of at least 8 hours because of verified improved clinical efficacy.
4. The therapeutic regimen is proven or generally accepted to have significant advantages over intermittent bolus administration regimens or infusions lasting less than 8 hours.

B. Criteria Set Two

1. Parenteral administration of the drug in the home is reasonable and necessary.
2. An infusion pump is necessary to safely administer the drug.
3. The drug is administered by intermittent infusion (each episode lasting less than 8 hours), which does not require a return to the physician's office before each episode.
4. Systemic toxicity or adverse effects of the drug is unavoidable without infusing it at a strictly controlled rate as indicated in the Physicians Desk Reference, American Medical Association's Drug Evaluations, or the U.S. Pharmacopoeia Drug Information.
5. Patient has significantly impaired renal function.

IV. Coverage of Pump based on Criteria Sets One and Two

Coverage of the pump for the administration of other drugs is based on criteria sets one and two and is limited to the following situations.

- A. Administration of the anticancer chemotherapy drugs cladribine, fluorouracil, cytarabine, bleomycin, floxuridine, doxorubicin, vincristine or vinblastine by continuous infusion over at least 8 hours when the regimen is proven or generally accepted to have significant advantages over intermittent administration.
- B. Administration of narcotic analgesics (except meperidine) in place of morphine to a patient with intractable pain caused by cancer who has not responded to an adequate oral/transdermal therapeutic regimen and/or cannot tolerate oral/transdermal narcotic analgesics.

- C. Administration of the antifungal or antiviral drugs: acyclovir, foscarnet, amphotericin B and ganciclovir.
- D. Pump authorization for the administration of parenteral inotropic therapy, using the drugs dobutamine, milrinone and/or dopamine for patients with congestive heart failure and depressed cardiac function if a patient meets all of the following criteria:
 1. Dyspnea at rest is present despite treatment with maximum or near maximum tolerated dose of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator (e.g., hydralzine or isosorbide dinitrate), used simultaneously (unless allergic or intolerant) and
 2. Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher dose levels):
 - (a) Dobutamine 2.5 -10 mcg/kg/min
 - (b) Milrinone 0.375- 0.750 mcg/kg/min
 - (c) Dopamine <2 mcg/kg/min and
 3. Cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), performed within 6 months prior to the initiation of more inotropic therapy showing (a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotrope infusion on maximum medical management and (b) at least 20% increase in CI and/or at least 20% decrease in PCWP during inotrope infusion at the dose initially prescribed for home infusion and
 4. There has been an improvement in patient well being, (less dyspnea, improved diuresis, 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 physician at least monthly and
 5. In the case of continuous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in the hospital, or in the case of intermittent infusions, there is documentation of repeated hospitalization for congestive heart failure despite maximum medical management and
 6. Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home and
 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 and

8. The patient's cardiac symptoms, vital signs, weight, lab values and response to therapy are routinely assessed and documented in the patient's medical record.
- E. Pump coverage for the administration of parenteral epoprostenol for patients with pulmonary hypertension if they meet the following disease criteria:
1. The pulmonary hypertension is not secondary to pulmonary venous hypertension (e.g., left-sided atrial or ventricular disease, left sided valvular heart disease, etc.) or disorders of the respiratory system (e.g., chronic obstructive pulmonary disease, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, alveolar hypoventilation disorders, etc.); and
 2. The patient has primary pulmonary hypertension or pulmonary hypertension, which is secondary to one of the following conditions: connective tissue disease, thromboembolic disease of the pulmonary arteries, human immunodeficiency virus (HIV), cirrhosis, diet drugs, congenital left to right shunts etc. If these conditions are present, the following criteria must be met:
 - (a) The pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition and
 - (b) The mean pulmonary artery pressure is greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion and
 - (c) The patient has significant symptoms from the pulmonary hypertension (i.e., severe dyspnea on exertion, and either fatigability, angina, or syncope); and
 - (d) Treatment with oral calcium channel blocking agents has been tried and failed or was considered and ruled out.
- F. For individuals with Gaucher disease who need slow rates of infusion of recombinant agent.
- G. Enzyme therapy exceptions will be considered. Documentation from the Department of Genetics must be submitted to the Utilization Review Section of the Division of Medical Services.
- H. Pump-coverage for the administration of liposomal amphotericin B for patients who meet one of the following criteria:
1. The patient has suffered some significant toxicity that would preclude the use of standard amphotericin B and is unable to complete that course of therapy without the liposomal form, or
 2. The patient has significantly impaired renal function.

Payment for the liposomal form will be based on the allowance for the least costly medically appropriate alternative, (standard amphotericin B) unless accompanied by a statement from the physician stating the need for the liposomal form.

V. Non-Covered Items

Disposable drug delivery systems, including elastomeric infusion pumps, are non-covered devices because they do not meet the Medicaid definition of durable medical equipment.

VI. Medical Supplies Allowed for Use of External Infusion Pump

The following medical supply items are covered during the period of covered use of the external infusion pump.

- A4221 Supplies for maintenance of a drug infusion catheter. (one per week) These supplies include those used for the flush, dressing change, restart, and care of the access site. (one per week)
- A4222 Supplies for external drug infusion pump, per cassette, (pump carried by the patient) or bag (when using a pump mounted to an IV pole). (one per day)

VII. Prior Authorization

Coverage of the external infusion pump and the medical supplies involved with its use require prior authorization from the Utilization Review Section of the Division of Medical Services. Prior authorization may be requested by submitting the Medical Equipment Request for Prior Authorization and Prescription form (form DMS-679) to Utilization Review.

The original and first copy of the Medical Equipment Request for Prior Authorization and Prescription form (DMS-679) must be forwarded to the following address:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Interim Director

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website:
www.medicaid.state.ar.us