

Final Rating: 2

All felt that NYHA class was important by virtue of being an eligibility criterion in many studies and yet all view NYHA class as inherently subjective, variably applied, and constantly changing for individual patients. There is really no evidence one way or another speaking to usefulness of NYHA class for study inclusion criteria. No evidence regarding HF class.

5. How do you rate the quality of evidence regarding the use of CRT in patients with Class I HF, LBBB, QRS >150 ms, EF \leq 30% on optimal medical therapy and an ischemic cardiomyopathy etiology?

Final Rating: 4 based on MADIT trial as noted above.

6. How do you rate the quality of evidence in support of CRT use for patients with EFs < 50%, but not in need of pacing?

Final Rating: 1 due to weak evidence for this practice.

7. How do you rate the quality of evidence in support of CRT for patients with EFs 35-50% AND a need for pacing?
- Does the potential for preservation of EF via CRT outweigh the risks of complications with CRT implant as compared to standard pacing and monitoring for progressive loss of LV function +/- increasing dyssynchrony?
 - How would you rate the quality of evidence in support of CRT use for patients with EFs < 50% and Class III-IV HF?
 - How would you rate the quality of evidence in support of CRT use for patients with EFs < 50% and Class III-IV HF and with LBBB > 130 ms?

Final Rating: 4.2

8. How do you rate the quality of evidence to support a requirement for at least 40% expected RV pacing in order to proceed with CRT?
- How should such an expectation be documented?

Final Rating: 3.8

All stated that documentation of an expected pacing rate should not be required by any policy and would be difficult to predict. This is really felt to be a standard care issue at this point.

9. How do you rate the quality of evidence in support of CRT implementation for patients with atrial fibrillation with HF and with LBBB QRS durations > 130 ms?
- If you feel the evidence is strong, should a provider be required to document his/her strategy toward effective, high frequency biventricular pacing (via AVN ablation or pharmacologic control of rate and PVC frequency)?

Final Rating: N/A

Upon discussion, agreed this is not an evidentiary question.

10. Regarding CRT upgrades, is there a degree of EF loss or an absolute EF % for which an upgrade to CRT from standard pacing is indicated?

Final Rating: 2

Evidence is not poor, there is just somewhat widespread practice on this point.

11. Your expert opinions on current restrictions to CRT mandating > 40 days after an MI are welcomed.

Final Rating: 4

Per BLOCK-HF trial, for those patients that need pacing, CRT is well supported, if needed; otherwise, wait.

12. Your expert opinions on possible restrictions to CRT for non-ischemic cardiomyopathy?

- a. How do you rate the quality of evidence for or against elapsed medical management periods of 3-9 months?

Final Rating: 4

Three months is reasonable. Waiting longer would not be needed and could be harmful.