Transcatheter Mitral Valve Replacement (TMVR)

Origination: September 17, 2014
Review Date: May 17, 2017
Next Review: May, 2019

DESCRIPTION OF PROCEDURE
Transcatheter Mitral Valve Replacement (TMVR) is a new technology for use in members with mitral valve regurgitation. The procedure involves clipping together a portion of the mitral valve leaflets as a treatment for reducing mitral regurgitation (MR) with the intended outcomes to improve recovery of the heart from overwork, improve function and potentially halt the progression of heart failure.

DEFINITIONS:
Coverage with Evidence Development (CED): CMS at times, issues a coverage decision with data collection being a part of the condition for coverage. The CED concept considers the item or service to be reasonable and necessary only while evidence is being developed regarding a member’s health outcomes in a clinical trial. CMS maintains a registry of facilities that have agreed to the clinical indications specified in the coverage decision. CMS lists clinical trials with CED at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Mitral-Valve-Repair-TMVR.html.

POLICY STATEMENT
Coverage will be provided for TMVR under CED based on meeting CMS conditions as outlined in the Coverage Decision Advisory, (CAG-00438N).

BENEFIT APPLICATION
Please refer to the member’s individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations, if the criteria are met.

Coverage decisions will be made in accordance with:
- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.
Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member’s particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

**INDICATIONS FOR COVERAGE**

1. **Preauthorization by the Plan is required; AND**
2. The medical director will review all TMVR requests.
3. Has to be performed in an inpatient facility; **AND**
4. The indication for coverage is symptomatic mitral valve regurgitation; **AND**
5. The device is FDA approved for symptomatic mitral valve regurgitation; **AND**
6. A cardiac surgeon and a cardiologist experienced in mitral valve surgery and disease have independently examined the patient face to face and evaluated the member’s suitability for open mitral valve surgery with determined risks and have documented their rationale for the TMVR; **AND**
7. The participating hospital must be in a clinical trial registry with a NCT number found at [https://www.ncdr.com/TVT/Home/Default.aspx](https://www.ncdr.com/TVT/Home/Default.aspx) or is listed on the CMS clinical trial under CED page

**WHEN COVERAGE WILL NOT BE APPROVED**

When the above criteria are not met.

**BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION**

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

*Applicable codes: 33418, 33419, 0345T*

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

**SPECIAL NOTES**

When the above criteria are met, staff will complete an inpatient authorization.

References:
2. U.S. Food and Drug Administration; MitralClip Clip Delivery System; viewed online at http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/Recently-ApprovedDevices/ucm375149.htm; viewed on 5/17/17.

Policy Implementation/Update Information:
New Policy: September 17, 2014
Revision Date: March 15, 2017: No updates to coverage criteria. No revisions to policy.
Revision Date: May 17, 2017: Indications for Coverage, #7. Updated hyperlink to https://www.ncdr.com/TVT/Home/Default.aspx and removed incorrect link. Removed AND from the end of sentence as this is the last criteria on the list.

Approval Dates:
Medical Coverage Policy Committee: May 17, 2017

Policy Owner: Carolyn Wisecarver, RN, BSN
Title: Medical Policy Coordinator