



# Louisiana

## Transcatheter Mitral Valve Repair

Policy # 00494

Original Effective Date: 02/17/2016

Current Effective Date: 09/14/2020

*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

### When Services May Be Eligible for Coverage

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider transcatheter mitral valve (MV) repair with a device approved by the U.S. Food and Drug Administration (FDA) for use in mitral valve (MV) repair to be **eligible for coverage\*\***, for patients with symptomatic, primary mitral regurgitation who are considered at prohibitive risk for open surgery (See Policy Guidelines section).

Based on review of available data, the Company may consider transcatheter mitral valve repair with a device approved by the U.S. Food and Drug Administration for patients with heart failure and moderate-to-severe or severe symptomatic secondary mitral regurgitation despite the use of maximally tolerated guideline-directed medical therapy to be **eligible for coverage\*\*** (See Policy Guidelines section).

### When Services Are Considered Investigational

*Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.*

Based on review of available data, the Company considers transcatheter mitral valve (MV) repair in all other situations to be **investigational.\***

### Policy Guidelines

"Prohibitive risk" for open surgery may be determined based on:

- Presence of a Society for Thoracic Surgeons predicted mortality risk of 12% or greater and/or

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- Presence of a logistic EuroSCORE of 20% or greater.

Moderate to severe or severe MR may be determined by:

- Grade 3+ (moderate) or 4+ (severe) MR confirmed by echocardiography
- New York Heart Association (NYHA) functional class II, III, or IVa (ambulatory) despite the use of stable maximal doses of guideline-directed medical therapy and cardiac resynchronization therapy (if appropriate) administered in accordance with guidelines of professional societies.

Optimal medical therapy may be determined by guidelines from specialty societies (e.g., American Heart Association/American College of Cardiology Guideline for the Management of Patients with Valvular Heart Disease, European Society of Cardiology/European Association for Cardio-Thoracic Surgery Guidelines for the Management of Valvular Heart Disease, American Heart Association/American College of Cardiology/Heart Failure Society of America Guideline for the Management of Heart Failure (refer to supplemental materials for guideline citations).

## **Background/Overview**

### **Mitral Regurgitation**

#### **Epidemiology and Classification**

Mitral Regurgitation (MR) is the second most common valvular heart disease, occurring in 7% of people older than age 75 years and accounting for 24% of all patients with valvular heart disease. MR with accompanying valvular incompetence leads to left ventricular (LV) volume overload with secondary ventricular remodeling, myocardial dysfunction, and left heart failure. Clinical signs and symptoms of dyspnea and orthopnea may also be present in patients with valvular dysfunction. MR severity is classified as mild, moderate, or severe disease on the basis of echocardiographic and/or angiographic findings (1+, 2+, and 3-4+ angiographic grade, respectively).

Patients with MR generally fall into two categories—primary (also called degenerative) and secondary (also called functional) MR. Primary MR results from a primary structural abnormality in the valve, which causes it to leak. This leak may result from a floppy leaflet (called prolapse) or a ruptured cord that caused the leaflet to detach partially (called flail). Because the primary cause is a structural abnormality, most cases of primary MR are surgically corrected. Secondary MR results

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from LV dilatation due to ischemic or dilated cardiomyopathy. This causes the mitral value (MV) leaflets not to coapt or meet in the center. Because the valves are structurally normal in secondary MR, correcting the dilated LV using medical therapy is the primary treatment strategy used in the U. S.

### Standard Management

#### Surgical Management

In symptomatic patients with primary MR, surgery is the main therapy. In most cases, MV repair is preferred over replacement, as long as the valve is suitable for repair and personnel with appropriate surgical expertise are available. The American College of Cardiology and the American Heart Association have issued joint guidelines on the surgical management of MV, which are outlined in Table 1.

**Table 1. Guidelines on Mitral Value Surgery**

<b>Recommendation</b>	<b>COR</b>	<b>LOE</b>
MV surgery is recommended for the symptomatic patient with acute severe MR.	I	B
MV surgery is beneficial for patients with chronic severe MR and NYHA functional class II, III, or IV symptoms in the absence of severe LV dysfunction (severe LV dysfunction is defined as ejection fraction less than 0.30) and/or end-systolic dimension greater than 55 mm.	I	B
MV surgery is beneficial for asymptomatic patients with chronic severe MR and mild-to-moderate LV dysfunction, ejection fraction 0.30 to 0.60, and/or end systolic dimension greater than or equal to 40 mm.	I	B
MV repair is recommended over MV replacement in the majority of patients with severe chronic MR who require surgery, and patients should be referred to surgical centers experienced in MV repair.	I	C
MV repair is also reasonable for asymptomatic patients with chronic severe MR with preserved LV function ... in whom the high likelihood of successful MV repair without residual MR is greater than 90%.	IIa	B

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MV surgery is reasonable for asymptomatic patients with chronic severe MR, preserved LV function, and new onset of atrial fibrillation	Ila	C
MV surgery is reasonable for asymptomatic patients with chronic severe MR, preserved LV function, and pulmonary hypertension....	Ila	C
MV surgery is reasonable for patients with chronic severe MR due to a primary abnormality of the mitral apparatus and NYHA functional class III-IV symptoms and severe LV dysfunction ... in whom MV repair is highly likely	Ila	C

COR: class of recommendation; LOE: level of evidence; LV: left ventricular; MR: mitral regurgitation; MV: mitral valve; NYHA: New York Heart Association.

The use of standard open MV repair is limited by the requirement for thoracotomy and cardiopulmonary bypass, which may not be tolerated by elderly or debilitated patients due to their underlying cardiac disease or other conditions. In a single-center evaluation of 5737 patients with severe MR in the U. S., Goel et al (2014) found that 53% of patients did not have MV surgery performed, suggesting an unmet need for such patients.

Isolated MV surgery (repair or replacement) for severe chronic secondary MR is not generally recommended because there is no proven mortality reduction and an uncertain durable effect on symptoms. Recommendations from major societies regarding MV surgery in conjunction with coronary artery bypass graft surgery or surgical aortic valve replacement are weak because the current evidence is inconsistent on whether MV surgery produces a clinical benefit.

### Transcatheter Mitral Valve Repair

Transcatheter approaches have been investigated to address the unmet need for less invasive MV repair, particularly among inoperable patients who face prohibitively high surgical risks due to age or comorbidities. MV repair devices under development address various components of the MV complex and generally are performed on the beating heart without the need for cardiopulmonary bypass. Approaches to MV repair include direct leaflet repair, repair of the mitral annulus via direct annuloplasty, or indirect repair based on the annulus's proximity to the coronary sinus. There are also devices in development to counteract ventricular remodeling, and systems designed for complete MV replacement via catheter.

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### **Direct Leaflet Approximation**

One device that undertakes direct leaflet repair, the MitraClip Clip Delivery System (Abbott Vascular), has been approved through the premarket approval process by the U.S. Food and Drug Administration (FDA) for use in certain patients with symptomatic primary MR (see Regulatory Status section). Of the transcatheter MV repair devices under investigation, MitraClip has the largest body of evidence evaluating its use; it has been in use in Europe since 2008. The MitraClip system is deployed percutaneously and approximates the open Alfieri edge-to-edge repair approach to treating MR. The delivery system consists of a catheter, a steerable sleeve, and the MitraClip device, which is a 4-mm wide clip fabricated from a cobalt-chromium alloy and polypropylene fabric. MitraClip is deployed via a transfemoral approach, with transseptal puncture used to access the left side of the heart and the MV. Placement of MitraClip leads to coapting of the mitral leaflets, thus creating a double-orifice valve.

### **Other Mitral Valve Repair Devices**

Devices for transcatheter MV repair that use different approaches are in development. Techniques to repair the mitral annulus include those that target the annulus itself (direct annuloplasty) and those that tighten the mitral annulus via manipulation of the adjacent coronary sinus (indirect annuloplasty). Indirect annuloplasty devices include the Carillon<sup>®</sup> Mitral Contour System (Cardiac Dimension) and the Monarc<sup>™</sup> device (Edwards Lifesciences). The CE-marked Carillon Mitral Contour System is comprised of self-expanding proximal and distal anchors connected with a nitinol bridge, with the proximal end coronary sinus ostium and the distal anchor in the great cardiac vein. The size of the connection is controlled by manual pullback on the catheter (CE-marked). The Carillon system was evaluated in the Carillon Mitral Annuloplasty Device European Union Study and the follow-up Tighten the Annulus Now study, with further studies planned. The Monarc system also involves two self-expanding stents connected by a nitinol bridge, with one end implanted in the coronary sinus via internal jugular vein and the other in the great cardiac vein. Several weeks after implantation, the biologically degradable coating over the nitinol bridge degrades, allowing the bridge to shrink and the system to shorten. It has been evaluated in the Clinical Evaluation of the Edwards Lifesciences Percutaneous Mitral Annuloplasty System for the Treatment of Mitral Regurgitation trial.

Direct annuloplasty devices include the Mitralign Percutaneous Annuloplasty System (Mitralign) and the AccuCinch<sup>®</sup> System (Guided Delivery Systems), both of which involve transcatheter placement of anchors in the MV; they are cinched or connected to narrow the mitral annulus. Other

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transcatheter direct annuloplasty devices under investigation include the enCorTC<sup>TM‡</sup> device (MiCardia), which involves a percutaneously insertable annuloplasty ring that is adjustable using radiofrequency energy, a variation on its CE-marked enCorsQ<sup>TM‡</sup> Mitral Valve Repair System, and the Cardioband<sup>TM‡</sup> Annuloplasty System (Valtech Cardio), an implantable annuloplasty band with a transfemoral venous delivery system.

### **Transcatheter Mitral Valve Replacement**

Permavalve<sup>TM‡</sup> (Micro Interventional Devices), under investigation in the U.S., is a transcatheter MV replacement device that is delivered via the transapical approach. On June 5, 2017, the SAPIEN 3 Transcatheter Heart Valve (Edwards Lifesciences) was approved by the FDA as MV replacement device. These replacement valves are outside the scope of this evidence review.

### **Medical Management**

The standard treatment for patients with chronic secondary MR is medical management. Patients with chronic secondary MR should receive standard therapy for heart failure with reduced ejection fraction; standard management includes angiotensin converting enzyme inhibitor (or angiotensin II receptor blocker or angiotensin receptor-neprilysin inhibitor),  $\beta$ -blocker and mineralocorticoid receptor antagonist, and diuretic therapy as needed to treat volume overload. Resynchronization therapy may provide symptomatic relief, improve LV function, and in some patients, lessen the severity of MR.

## **FDA or Other Governmental Regulatory Approval**

### **U.S. Food and Drug Administration (FDA)**

In October 2013, the MitraClip<sup>®‡</sup> Clip Delivery System (Abbott Vascular) was approved by the FDA through the premarket approval process for treatment of “significant symptomatic mitral regurgitation (MR  $\geq 3+$ ) due to primary abnormality of the mitral apparatus (degenerative MR) in patients who have been determined to be at a prohibitive risk for mitral valve surgery by a heart team.” FDA product code: NKM.

In March 2019, the FDA approved a new indication for MitraClip, for “treatment of patients with normal mitral valves who develop heart failure symptoms and moderate-to-severe or severe mitral regurgitation because of diminished left heart function (commonly known as secondary or functional mitral regurgitation) despite being treated with optimal medical therapy. Optimal medical therapy

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includes combinations of different heart failure medications along with, in certain patients, cardiac resynchronization therapy and implantation of cardioverter defibrillators."

### **Rationale/Source**

Transcatheter mitral valve repair (TMVR) is an alternative to surgical therapy for mitral regurgitation (MR). MR is a common valvular heart disease that can result from a primary structural abnormality of the mitral valve (MV) complex or a secondary dilatation of an anatomically normal MV due to a dilated left ventricle caused by ischemic or dilated cardiomyopathy. Surgical therapy may be underutilized, particularly in patients with multiple comorbidities, suggesting that there is an unmet need for less invasive procedures for MV repair. One device, MitraClip, has approval from the U.S. Food and Drug Administration for the treatment of severe symptomatic MR due to a primary abnormality of the MV (primary MR) in patients considered at prohibitive risk for surgery and for patients with heart failure and moderate-to-severe or severe symptomatic secondary MR despite the use of maximally tolerated guideline-directed medical therapy.

For individuals who have symptomatic primary MR and at prohibitive risk for open surgery who receive TMVR using MitraClip, the evidence includes a single-arm prospective cohort with historical cohort and registry studies. Relevant outcomes are overall survival (OS), morbid events, functional outcomes, and treatment-related morbidity. The primary evidence includes the pivotal EVEREST II HRR and EVEREST II REALISM studies and Transcatheter Valve Therapy Registry studies. These studies have demonstrated that MitraClip implantation is feasible with a procedural success rate greater than 90%, 30-day mortality ranging from 2.3% to 6.4% (less than predicted Society of Thoracic Surgeons mortality risk score for MR repair or replacement; range, 9.5%-13.2%), postimplantation MR severity grade of 2+ or less in 82% to 93% of patients, and a clinically meaningful gain in quality of life (5- to 6-point gains in 36-Item Short-Form Health Survey scores). At 1 year, freedom from death and MR more than 2+ was achieved in 61% of patients but the 1-year mortality or heart failure hospitalization rates remain considerably high (38%). Conclusions related to the treatment effect on mortality based on historical controls cannot be made because the control groups did not provide unbiased or precise estimates of the natural history of patients eligible to receive MitraClip. Given that primary MR is a mechanical problem and there is no effective medical therapy, a randomized controlled trial (RCT) comparing MitraClip with medical management is not feasible or ethical. The postmarketing data from the U.S. is supportive that MitraClip surgery is being performed with short-term effectiveness and safety in select patient population. The evidence

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is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have heart failure and symptomatic secondary MR despite the use of maximally tolerated guideline-directed medical therapy who receive TMVR using MitraClip, the evidence includes a systematic review, two RCTS as well as multiple observational studies. Relevant outcomes are OS, morbid events, functional outcomes, and treatment-related morbidity. The trials had discrepant results potentially related to differences in primary outcomes. The larger trial, with patients selected for nonresponse to maximally tolerated therapy, found a significant benefit for MitraClip after two years compared to medical therapy alone. The systematic review confirmed the benefit of MitraClip found in the larger RCT, but had important methodological limitations. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have symptomatic primary or SMR and are surgical candidates who receive TMVR using MitraClip, the evidence includes a systematic review, 1 RCT and a retrospective comparative observational study in individuals aged  $\geq 75$  years. Relevant outcomes are OS, morbid events, functional outcomes, and treatment-related morbidity. The RCT found that MitraClip did not reduce MR as often or as completely as the surgical control, although it could be safely implanted and was associated with fewer adverse events at one year. Long-term follow-up from the RCT showed that significantly more MitraClip patients required surgery for MV dysfunction than conventional surgery patients. For these reasons, this single trial is not definitive in demonstrating improved clinical outcomes with MitraClip compared with surgery. Additional RCTs are needed to corroborate these results. The observational study in individuals aged  $\geq 75$  years found that although MitraClip was associated with improved 1-year survival and a lower rate of all acute complications compared with surgical repair, it had lower 5-year survival and greater MR recurrence. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have symptomatic primary or secondary MR who receive TMVR using devices other than MitraClip, the evidence includes primarily noncomparative feasibility studies. Relevant outcomes are OS, morbid events, functional outcomes, and treatment-related morbidity. The body of evidence consists only of very small case series and case reports. Controlled studies, preferably RCTs, are needed to draw conclusions about the net health benefit. The evidence is insufficient to determine the effects of the technology on health outcomes.

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Clinical input obtained in 2015 supported the use of TMVR in patients with primary MR considered at a prohibitive risk for open surgery, which is a U.S. Food and Drug Administration approved indication for the MitraClip device. Given the lack of other treatment options for this population, the suggestive clinical evidence, and supportive clinical input, TMVR with the MitraClip may be considered medically necessary for this patient population.

### **Supplemental Information**

#### **Clinical Input From Physician Specialty Societies and Academic Medical Centers**

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 4 academic medical centers, one of which provided 4 responses, for a total of 7 responses, while this policy was under review in 2015. Input supported the use of transcatheter mitral valve repair in patients with primary (degenerative) mitral regurgitation at prohibitive risk of open surgery. The greatest consensus for selection criteria to determine “prohibitive risk” was for the use of the Society of Thoracic Surgeons predictive operative risk of 12% or higher, or a logistic EuroSCORE of 20% or higher.

#### **Practice Guidelines and Position Statements**

##### **American College of Cardiology**

The American College of Cardiology and American Heart Association (2017) released guidelines on the management of valvular heart disease. Table 2 provides the relevant recommendations.

**Table 2. Recommendations on Primary and Secondary MR**

<b>Recommendation</b>	<b>SOR</b>	<b>LOE</b>
Primary MR		
Transcatheter mitral valve repair may be considered for severely symptomatic patients (NYHA class III to IV) with chronic severe primary MR (stage D) who have favorable anatomy for the repair procedure and a reasonable life expectancy	Iib	B

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but who have a prohibitive surgical risk because of severe comorbidities and remain severely symptomatic despite optimal guideline-directed medical therapy for heart failure		
Secondary MR		
Mitral valve surgery is reasonable for patients with chronic severe secondary MR (stages C and D) who are undergoing CABG or AVR.	I Ib	B
Mitral valve repair or replacement may be considered for severely symptomatic patients (NYHA class III to IV) with chronic severe secondary MR (stage D) who have persistent symptoms despite optimal GDMT for HF.	I Ib	B-R

AVR: aortic valve replacement; B-R: moderate-quality evidence; CABG: coronary artery bypass grafting; GDMT: guideline-directed medical therapy; HF: heart failure; MR: mitral regurgitation; NYHA: New York Heart Association; LOE: level of evidence; SOR: strength of recommendation.

The American College of Cardiology, American Association for Thoracic Surgery, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons (2014) issued a position statement on transcatheter therapies for mitral regurgitation (MR). This statement outlined critical components for successful transcatheter MR therapies and recommended ongoing research and inclusion of all patients treated with transcatheter MR therapies in a disease registry.

### European Society of Cardiology and European Association for Cardio-Thoracic Surgery

The European Society of Cardiology and the European Association for Cardio-Thoracic Surgery (2017) released joint guidelines on the management of valvular heart disease (see Table 3).

**Table 3. Recommendations on Management of Valvular Heart Disease**

Recommendation	SOR	LOE
Primary MR		
Percutaneous edge-to-edge procedure may be considered in patients with symptomatic severe primary mitral regurgitation who fulfill the echocardiographic criteria of eligibility and are judged inoperable or at high surgical risk by the Heart Team, avoiding futility.	I Ib	C

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Secondary MR		
“Percutaneous edge-to-edge repair for secondary mitral regurgitation is a low risk option, but its efficacy to reduce mitral regurgitation remains inferior to surgery. It can improve symptoms, functional capacity and quality of life and may induce reverse LV remodelling. Similar to surgery, a survival benefit compared with ‘optimal’ medical therapy according to current guidelines has not yet been proven.”	a	a

LOE: level of evidence; LV: left ventricular; SOR: strength of recommendation.

<sup>a</sup> No specific recommendations.

### U.S. Preventive Services Task Force Recommendations

Not applicable.

### Medicare National Coverage

The Centers for Medicare & Medicaid Services (2015) issued a national coverage decision for the use of transcatheter mitral valve repair (TMVR).

The Centers for Medicare & Medicaid Services determined that it would cover TMVR under Coverage with Evidence Development for the treatment of significant symptomatic MR when all of the following conditions are met:

- “1. The procedure is performed with a complete TMVR system that has received FDA [Food and Drug Administration] premarket approval (PMA) for that system’s FDA approved indication.
2. Both a cardiothoracic surgeon experienced in mitral valve surgery and a cardiologist experienced in mitral valve disease have independently examined the patient face-to-face and evaluated the patient’s suitability for mitral valve surgery and determination of prohibitive risk; and both surgeons have documented the rationale for their clinical judgment and the rationale is available to the heart team.
3. The patient (pre-operatively and post-operatively) is under the care of a heart team....  
TMVR must be furnished in a hospital and with the appropriate infrastructure that includes but is not limited to:
  - a. On-site active valvular heart disease surgical program with >2 hospital-based cardiothoracic surgeons experienced in valvular surgery;

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- b. Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering catheterization laboratory-quality imaging,
- c. Non-invasive imaging expertise including transthoracic/transesophageal/3D echocardiography, vascular studies, and cardiac CT studies; ...
- e. Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures;
- f. Adequate outpatient clinical care facilities
- g. Appropriate volume requirements per the applicable qualifications below.

There are institutional and operator requirements for performing TMVR. The hospital must have the following:

- a. A surgical program that performs > 25 total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- b. An interventional cardiology program that performs > 1000 catheterizations per year, including > 400 percutaneous coronary interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- c. The heart team must include:
  - 1. An interventional cardiologist(s) who:  
performs > 50 structural procedures per year including atrial septal defects (ASD), patent foramen ovale (PFO) and trans-septal punctures; and, must receive prior suitable training on the devices to be used; and, must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States;
  - 2. Additional members of the heart team, including: cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists, electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator;
- d. All cases must be submitted to a single national database;
- e. Ongoing continuing medical education (or the nursing/technologist equivalent) of 10 hours per year of relevant material;

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- f. The cardiothoracic surgeon(s) must be board-certified in thoracic surgery or similar foreign equivalent.
- 4. The heart teams [sic] interventional cardiologist or a cardiothoracic surgeon must perform the TMVR. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.
- 5. The heart team and hospital are participating in a prospective, national, audited registry that: 1) consecutively enrolls TMVR patients; 2) accepts all manufactured devices; 3) follows the patient for at least one year; and, 4) complies with relevant regulations relating to protecting human research subjects....

The registry should collect all data necessary and have a written executable plan....

TMVR for MR uses that are not expressly listed as an FDA-approved indication when performed within a FDA-approved randomized clinical trial that fulfills all of the following:

- 1. TMVR must be performed by an interventional cardiologist or a cardiac surgeon. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.
- 2. As a fully-described, written part of its protocol, the clinical research study must critically evaluate the following questions at 12 months of longer follow-up:

What is the patient’s post-TMVR quality of life (compared to pre-TMVR) at one year?

What is the patient’s post-TMVR functional capacity (compared to pre-TMVR) at one year?”

In addition, the clinical research study must address a series of questions at one year postprocedure as outlined in the proposed decision memo.

### Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 4.

**Table 4. Summary of Key Trials**

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			

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NCT01920698	Multicentre Randomized Study of Percutaneous Mitral Valve Repair MitraClip Device in Patients With Severe Secondary Mitral Regurgitation (MITRA-FR)	288	Apr 2019
NCT03521921	GIse Registry Of Transcatheter Treatment of Mitral Valve regurgitaTiOn (GIOTTO)	1100	Feb 2021
NCT02444338	A Clinical Evaluation of the Safety and Effectiveness of the MitraClip System in the Treatment of Clinically Significant Functional Mitral Regurgitation (RESHAPE-HF)	420	Mar 2021
NCT04009434	Treatment of Concomitant Mitral Regurgitation by Mitral Valve Clipping in Patients With Successful Transcatheter Aortic Valve Implantation	1162	Aug 2023
NCT01626079	Cardiovascular Outcomes Assessment of the MitraClip Percutaneous Therapy for Heart Failure Patients With Functional Mitral Regurgitation (The COAPT Trial)	610	July 2024 (5-year follow-up per protocol)
NCT04198870	Percutaneous MitraClip Device or Surgical Mitral Valve REpair in PATients With PrImaRy MItral Regurgitation Who Are Candidates for Surgery (REPAIR MR)	500	Feb 2027

NCT: national clinical trial.

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## Policy History

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02/04/2016 Medical Policy Committee review

02/17/2016 Medical Policy Implementation Committee approval. New Policy

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- 01/01/2017 Coding update: Removing ICD-9 Diagnosis Codes
- 02/02/2017 Medical Policy Committee review
- 02/15/2017 Medical Policy Implementation Committee approval. No change to coverage.
- 02/01/2018 Medical Policy Committee review
- 02/21/2018 Medical Policy Implementation Committee approval. No change to coverage.
- 02/07/2019 Medical Policy Committee review
- 02/20/2019 Medical Policy Implementation Committee approval. Degenerative mitral regurgitation was replaced with primary mitral regurgitation and functional mitral regurgitation was replaced with secondary mitral regurgitation including the policy statement to be in consistent with language used in the guidelines.
- 08/01/2019 Medical Policy Committee review
- 08/14/2019 Medical Policy Implementation Committee approval. Added “Based on review of available data, the Company may consider transcatheter mitral valve repair with a device approved by the U.S. Food and Drug Administration for patients with heart failure and moderate-to-severe or severe symptomatic secondary mitral regurgitation despite the use of maximally tolerated guideline-directed medical therapy to be eligible for coverage\*\*” Added Policy Guidelines section.
- 08/06/2020 Medical Policy Committee review
- 08/12/2020 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 08/2021

### **Coding**

*The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2019 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.*

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Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	0345T, 0544T, 33418, 33419
HCPCS	No codes
ICD-10 Diagnosis	All related diagnoses

\*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
  - 1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);

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2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

\*\*Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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