Overview

This Coverage Policy addresses the transcatheter (percutaneous or catheter-based) approach for aortic or pulmonary heart valve replacement, percutaneous mitral valve repair and percutaneous tricuspid valve repair or replacement and cerebral protection devices.

Coverage Policy

Transcatheter aortic valve implantation using a U.S. Food and Drug Administration (FDA) approved device is considered medically necessary when the following device-specific criteria are met:

- Edwards SAPIEN™ Transcatheter Heart Valve [Edwards Lifesciences, LLC, Irvine, CA] for ALL of the following:
  - severe symptomatic calcified native aortic valve stenosis without severe aortic insufficiency
  - ejection fraction > 20%
  - EITHER of the following:
    - inoperable as determined by the heart team, including an experienced cardiac surgeon and a cardiologist, and existing comorbidities would not preclude the expected benefit from correction of the aortic stenosis
    - operative candidate for aortic valve replacement but with a Society of Thoracic Surgeons predicted operative risk score ≥ 8%, or are judged by the heart team to be at a ≥ 15% risk of mortality for surgical aortic valve replacement
• Edwards SAPIEN™ XT Transcatheter Heart Valve [Edwards Lifesciences, LLC, Irvine, CA] OR Medtronic CoreValve System Transcatheter Aortic Valve [Medtronic CoreValve LLC, Santa Rosa, CA]) for ALL of the following:
  ➢ symptomatic heart disease due to severe native calcific aortic stenosis (i.e., aortic valve area ≤ 1.0 cm² or aortic valve area index ≤ 0.6 cm²/m², a mean aortic valve gradient of ≥ 40mm Hg, or a peak aortic-jet velocity of ≥ 4.0 m/s)
  ➢ appropriate native anatomy
  ➢ judged by a heart team, including a cardiac surgeon, to be at high (or greater) risk for open surgical therapy (i.e., Society of Thoracic Surgeons operative risk score ≥ 8% or at a ≥ 15% risk of mortality at 30 days)

• Edwards SAPIEN 3 Transcatheter Heart Valve [Edwards Lifesciences, LLC, Irvine, CA] for ALL of the following:
  ➢ severe symptomatic calcified native aortic valve stenosis
  ➢ judged by a heart team, including a cardiac surgeon, to be at high (or greater) risk for open surgical therapy (i.e., Society of Thoracic Surgeons operative risk score ≥ 8% or at a ≥ 15% risk of mortality at 30 days)

• Edwards SAPIEN™ XT, Edwards SAPIEN 3 Transcatheter Heart Valve [Edwards Lifesciences, LLC, Irvine, CA] OR Medtronic CoreValve System, CoreValve Evolut R System; CoreValve Evolut PRO System Transcatheter Aortic Valve [Medtronic CoreValve LLC, Santa Rosa, CA]) for ALL of the following:
  ➢ symptomatic heart disease due to severe native calcific aortic stenosis
  ➢ judged by a heart team, including a cardiac surgeon, to be at intermediate (or greater) risk for open surgical therapy (i.e., predicted risk of surgical mortality ≥ 3% at 30 days, based on the Society of Thoracic Surgeons (STS) risk score and other clinical co-morbidities unmeasured by the STS risk calculator)

Transcatheter aortic valve implantation for any other indication is considered experimental, investigational or unproven.

Transcatheter pulmonary valve implantation using a U.S. Food and Drug Administration (FDA) approved device is considered medically necessary when the following device-specific criteria are met:
• Medtronic Melody® Transcatheter Pulmonary Valve (Medtronic, Inc., Santa Ana, CA) for ALL of the following:
  ➢ existence of a full (circumferential) right ventricular outflow tract (RVOT) conduit that was equal to or greater than 16 mm in diameter when originally implanted
  ➢ dysfunctional RVOT conduit with a clinical indication for intervention, and EITHER of the following:
    o moderate or greater regurgitation
    o stenosis, with mean RVOT gradient ≥ 35 mmHg

• Edwards SAPIEN™ XT Transcatheter Heart Valve and Accessories [Edwards Lifesciences, LLC, Irvine, CA] for ALL of the following:
  ➢ dysfunctional, non-compliant RVOT conduit with a clinical indication for intervention
  ➢ pulmonary regurgitation ≥ moderate and/or mean RVOT gradient ≥ 35 mmHg
Transcatheter pulmonary valve implantation for any other indication is considered experimental, investigational or unproven.

Percutaneous mitral valve repair using a U.S. Food and Drug Administration (FDA) approved device is considered medically necessary when the following device-specific criteria are met:
- MitraClip NT Clip Delivery System (CDS) and MitraClip NTR/XTR (Abbott Vascular, Menlo Park, CA) for ALL of the following:
  - symptomatic mitral regurgitation (MR ≥ 3+) due to primary abnormality of the mitral apparatus (degenerative MR)
  - determined to be at prohibitive risk for mitral valve surgery by a heart team, which includes a cardiac surgeon experienced in mitral valve surgery and a cardiologist experienced in mitral valve disease, and in whom existing comorbidities would not preclude the expected benefit from reduction of the MR

Percutaneous mitral valve repair for any other indication is considered experimental, investigational or unproven.

The following transcatheter heart valve devices and/or procedures are considered experimental, investigational or unproven:
- transcatheter mitral valve implantation or replacement
- percutaneous tricuspid valve repair or replacement
- cerebral protection devices (e.g., Sentinel™ Cerebral Protection System)

**General Background**

**Aortic Valve**
Valvular aortic stenosis is a narrowing or obstruction of the aortic valve that prevents the valve leaflets from opening normally. Medication is prescribed to alleviate symptoms. Surgical aortic valve replacement reduces symptoms and improves survival in patients with severe aortic stenosis, and is considered the surgical treatment of choice for most adults. As many as a third of patients with severe heart valve disease are considered too high risk for conventional surgical valve replacement. Transcatheter aortic valve implantation (TAVI), also referred to as transcatheter aortic valve replacement (TAVR) or percutaneous aortic valve replacement, was first accomplished in 2002. TAVI or TAVR has been proposed as a less invasive alternative to open surgical aortic valve replacement in a specific subset of patients. TAVI or TAVR is a minimally invasive surgical procedure that repairs the valve without removing the old, damaged valve. Instead, it wedges a replacement valve into the aortic valve’s place. This is referred to a valve-in-valve procedure. Somewhat similar to a stent placed in an artery, the TAVI approach delivers a fully collapsible replacement valve to the valve site through a catheter. Once the new valve is expanded, it pushes the old valve leaflets out of the way and the tissue in the replacement valve takes over the job of regulating blood flow (Herrmann, et al., 2019; American Heart Association (AHA), 2016).

Several techniques for TAVI have been described in the literature. Currently, 85-90% of all TAVR valves are implanted by a transfemoral approach (Grover, 2017). For patients in whom a transfemoral approach is not feasible, a number of other alternative access routes are used. The original transapical delivery and direct transaortic route are now seldom used for TAVR. The more preferred alternative access approach currently is a subclavian approach, usually the left. Other alternative access approaches include transcaval, transcortid, and transmediastinal (Herrmann, et al., 2019).

TAVI has become established as a treatment option for elderly, inoperable and high-risk patients with severe aortic stenosis. Increased operator experience and enhanced transcatheter valve systems have led to a worldwide trend to use TAVR in patients who are at low or intermediate risk. This trend has been evaluated in randomized controlled and small observational studies. Since Most patients who are currently recommended for surgery are at low or intermediate risk. It has been reported that approximately 80% of patients with aortic stenosis have a low surgical risk. The expansion of the use of TAVR requires rigorous clinical-trial validation with long-term follow-up (Overtchouk, et al., 2019; Leon, et al., 2016).
The currently available TAVR valves approved by the U.S. Food and Drug Administration (FDA) include the balloon-expandable Edwards Sapien XT™ and Sapien 3 (Edwards Lifesciences, Irvine, CA) and self-expandable Medtronic Evolut R and Evolut PRO systems (Medtronic, Inc., Santa Rosa, CA). The choice of valve depends on anatomic reasons and operator preference and experience (Arshi, et al., 2019). These two transcatheter aortic valve systems have undergone numerous design and labeling changes as described in the U.S. Food and Drug Administration (FDA) section of the Coverage Policy.

The complications associated with TAVR have been somewhat addressed by improvements in devices, technique, delivery, and patient selection. These complications include paravalvular leak, stroke, valve thrombosis and need for a new, permanent pacemaker. The incidence of clinically evident stroke both in randomized trials when examined by a neurologist and in clinical registries ranges from 2-9%. The incidence of moderate to severe paravalvular leak was significantly problematic in the initial trials of TAVR. Improvements in valve design and increased availability of additional valve sizes have decreased the incidence of moderate to severe paravalvular leak to the range of 3-6%, although mild paravalvular regurgitation occurs in up to one third of patients. The requirement for a new, permanent pacemaker in many patients continues to be an issue with TAVR. The incidence ranges from approximately 10-30%, with most current studies closer to the lower end of this range. Patients with preexisting conduction system abnormalities are particularly prone to develop increased conduction system block after TAVR and thus require a new, permanent pacemaker. Another concern associated with TAVR is valve leaflet thickening and thrombosis. The subsequent expanded use of imaging modalities in surveillance studies revealed an incidence of approximately 7-10%. Randomized studies to five years and single-center experience up to 10 years have not yet shown a major reason for concern regarding valve durability (Mack, et al., 2015; Daubert, et al., 2016). The studies are subject to survivorship bias, and with small numbers of patients alive at five years or longer after the procedure, the ultimate issue of durability with surgical valves remains undetermined (Herrmann, et al., 2019).

U.S. Food and Drug Administration (FDA)--Edwards SAPIEN™ Transcatheter Heart Valve (Edwards Lifesciences, LLC, Irvine, CA): The Edwards SAPIEN™ Transcatheter Heart Valve model 9000TFX, 23 and 26 mm, and accessories (RetroFlex™ 3 Delivery System, models 9120FS23 and 9120FS26 RetroFlex Balloon Catheter, models 9120BC20 and 9120BC23 Crimper, models 9100CR23 and 9100CR26) received FDA approval through the PMA process on November 2, 2011 (P100041). The SAPIEN Transcatheter Heart Valve was approved for transfemoral delivery in patients with severe symptomatic native aortic valve stenosis, determined by a cardiac surgeon to be inoperable for open aortic valve replacement and in whom existing comorbidities would not preclude the expected benefit from correction of the aortic stenosis.

On October 19, 2012, an additional PMA approval (P110021) was granted, allowing a transapical delivery approach in addition to a transfemoral approach. Indications for use were also expanded. On September 23, 2013 (P11021/S026), the FDA approved removal of the access approach from the device labeling. As revised, the device is indicated for patients with severe symptomatic calcified native aortic valve stenosis without severe aortic insufficiency and with ejection fraction > 20% who have been examined by a heart team including an experienced cardiac surgeon and a cardiologist and found to be: 1) inoperable and in whom existing co-morbidities would not preclude the expected benefit from correction of the aortic stenosis; or 2) be operative candidates for aortic valve replacement but who have a predicted operative risk score ≥ 8% or are judged by the heart team to be at a ≥ 15% risk of mortality for surgical aortic valve replacement.

On June 16, 2014, the Edwards SAPIEN XT™ Transcatheter Heart Valve model 9300TFX, 23, 26, and 29 mm, and accessories received FDA PMA approval (P130009). This next-generation, lower profile system includes a 29 mm valve size for patients with a larger native annulus. The device is indicated for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis (aortic valve area ≤ 1.0 cm², or aortic valve area index ≤ 0.6 cm²/m², a mean aortic valve gradient of ≥ 40 mm/Hg, or a peak aortic-jet velocity of ≥ 4.0 m/s), and with native anatomy appropriate for the 23, 26, or 29 mm valve system, who are judged by a heart team, including a cardiac surgeon, to be at high or greater risk for open surgical therapy (i.e., Society of Thoracic Surgeons operative risk score ≥ 8% or at a ≥ 15% risk of mortality at 30 days).

In a PMA supplement approved on October 25, 2015 (P130009/S034), the FDA expanded the indications for the Edwards SAPIEN XT™ Transcatheter Heart Valve, model 9300TFX, 23, 26, and 29 mm, and accessories to
include use in patients with symptomatic heart disease due to either severe native calcific aortic stenosis or failure (stenosed, insufficient, or combined) of a surgical bioprosthetic aortic valve who are judged by a heart team, including a cardiac surgeon, to be at high or greater risk for open surgical therapy (i.e., Society of Thoracic Surgeons operative risk score ≥ 8% or at a ≥ 15% risk of mortality at 30 days).

In PMA supplements approved on August 18, 2016 (P130009/S057 and P140031/010), the FDA expanded the indications for the Edwards SAPIEN XT™ Transcatherter Heart Valve, model 9300TFX, 23, 26, and 29 mm, and accessories and the SAPIEN 3 Transcatheter Heart Valve and accessories model 9600TFX to include relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis who are judged by a heart team, including a cardiac surgeon, to be at intermediate or greater risk for open surgical therapy (i.e., predicted risk of surgical mortality ≥ 3% at 30 days, based on the Society of Thoracic Surgeons (STS) risk score and other clinical co-morbidities unmeasured by the STS risk calculator). Data from the PARTNER II Trial Intermediate Risk Cohort A (denoted as PIIA) was the basis for the PMA approval decision for the SAPIEN XT. Data from the Partner II (denoted as PIIS3i) cohort were the basis for the SAPIEN 3 PMA approval. The manufacturer is required to follow these patients for 10 years to further monitor safety and effectiveness, as a condition of FDA approval.

On June 17, 2015, the SAPIEN 3 Transcatheter Heart Valve and accessories model 9600TFX received FDA PMA approval (P140031). This third generation device has a major design change that adds a skirt at the base of the valve to minimize leakage around the valve. The device is indicated for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis who are judged by a heart team, including a cardiac surgeon, to be at high or greater risk for open surgical therapy (i.e., Society of Thoracic Surgeons operative risk score ≥ 8% or at a ≥ 15% risk of mortality at 30 days).

In a PMA supplement approved on June 5, 2017 (P140031/S028) the FDA approved expanded use of the SAPIEN 3 Transcatheter Heart Valve, Model 9600TFX for treatment of individuals with symptomatic heart disease due to failure (stenosed, insufficient, or combined) of a surgical bioprosthetic aortic or mitral valve who are judged by a heart team, including a cardiac surgeon, to be at high or greater risk for open surgical therapy (i.e., predicted risk of surgical mortality ≥ 8% at 30 days, based on the STS risk score and other clinical co-morbidities unmeasured by the STS risk calculator). The FDA Summary of Safety and Effectiveness Data reports in the summary of primary clinical data that the applicant performed an analysis of the real-world off-label use data captured in the Society of Thoracic Surgeons (STS)/American College of Cardiology (ACC) Transcatheter Valve Therapy (TVT) Registry to establish a reasonable assurance of safety and effectiveness of transcatheter valve replacement with the Edwards SAPIEN 3 THV in patients with a failed surgical aortic or mitral bioprosthesis who are at high or greater surgical risk for reoperative aortic or mitral valve replacement. The data from the TVT Registry were the basis of the PMA supplemental approval decision. Valve function before valve-in-valve repair, upon discharge and 30 days post procedure was reported in the data.

In a PMA supplement approved on August 16, 2019 (P140031/S085) the FDA approved the Edwards SAPIEN 3 Transcatheter Heart Valve System and Edwards SAPIEN 3 Ultra Transcatheter Heart Valve System to include patients at low risk for surgical aortic valve replacement. The devices are indicated for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis who are judged by a heart team, including a cardiac surgeon, to be appropriate for the transcatheter heart valve replacement therapy. Data from the Placement of Aortic Transcatheter Valves (PARTNER) 3 Trial (Mack, et al., 2019) was the basis for the PMA approval decision (NCT02675114).

Medtronic CoreValve™ (MCS) System Transcatheter Aortic Valve (TAV) (Medtronic CoreValve LLC, Santa Rosa, CA): The MCS TAV models MCS-P4-23-AOA (23 mm CoreValve Evolut), MCS-P3-26-AOA (26 mm), MCS-P3-29-AOA (29 mm) and MCS-P3-31-AOA (31 mm); Delivery Catheter System (DCS), Models DCS-C4-18FR and DCS-C4-18FR-23; and Compression Loading System Model CLS-3000-18FR received FDA approval through the PMA process on January 17, 2014 (P130021).

According to the FDA labeling, the Medtronic CoreValve™ System is indicated for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis (aortic valve area ≤0.8 cm2, a mean aortic valve gradient of >40 mm Hg, or a peak aortic-jet velocity of >4.0 m/s) and with native aortic annulus diameters between 18 and 29 mm who are judged by a heart team, including a cardiac surgeon, to be at
extreme risk or inoperable for open surgical therapy (predicted risk of operative mortality and/or serious irreversible morbidity ≥50% at 30 days).

In a PMA supplement approved on June 12, 2014 (P130021/S002), the FDA expanded the indications for the CoreValve System. According to the revised PMA approval, the CoreValve is indicated for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis (aortic valve area ≤ 1.0 cm² or aortic valve area index ≤ 0.6 cm²/m², a mean aortic valve gradient of ≥ 40 mm Hg, or a peak aortic-jet velocity of ≥ 4.0 m/s) and with native anatomy appropriate for the 23, 26, 29, or 31 mm valve system who are judged by a heart team, including a cardiac surgeon, to be at high or greater risk for open surgical therapy (i.e., Society of Thoracic Surgeons operative risk score ≥ 8% or at a ≥ 15% risk of mortality at 30 days).

In a PMA supplement approved on March 20, 2015 (P130021/S010), the FDA expanded the indications for the CoreValve System to include the treatment of a failed surgical bioprosthesis (TAV -in-SAV). According to the revised PMA approval, the CoreValve is indicated for use in patients with symptomatic heart disease due to either severe native calcific aortic stenosis or failure (stenosed, insufficient, or combined) of a surgical bioprosthetic aortic valve who are judged by a heart team, including a cardiac surgeon, to be at high or greater risk for open surgical therapy (i.e., Society of Thoracic Surgeons operative risk score ≥8% or at a ≥15% risk of mortality at 30 days).

In a PMA supplement approved on June 22, 2015 (P130021/S014), the FDA approved a change in the design iteration of the 23, 26, and 29 mm Medtronic CoreValve System. According to the revised PMA approval, the new components include CoreValve™ Evolut R® transcatheter aortic valves, models Evolut R-23mm, Evolut R-26mm, and Evolut R-29mm, EnVeo R delivery catheter system, model EnVeo R, and EnVeo R loading systems. These components will be marketed under the trade name CoreValve Evolut R System.

In a PMA supplement approved on March 20, 2017 (P130021/S029), the FDA approved a design iteration of the 23, 26, and 29 mm Medtronic CoreValve Evolut R System. The new components include the CoreValve Evolut PRO Transcatheter Aortic Valves, models EVOLUTPRO-23-US, EVOLUTPRO-26-US, and EVOLUTPRO-29-US, and the EnVeo R Loading Systems, models LS-MDT2-23-US and LS-MDT2-2629-US.

In a PMA supplement approved on July 10, 2017 (P130021/S033), the FDA expanded FDA approval of the CoreValve System; CoreValve Evolut R System; CoreValve Evolut PRO System for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis who are judged by a heart team, including a cardiac surgeon, to be at intermediate or greater risk for open surgical therapy (i.e., predicted risk of surgical mortality ≥3% at 30 days, based on the Society of Thoracic Surgeons (STS) risk score and other clinical co-morbidities unmeasured by the STS risk calculator). The FDA approval is based on two year results from the SURTAVI trial (NCT01586910), a randomized study comparing TAVR (CoreValve System) with surgical aortic valve replacement in individuals with severe, symptomatic aortic stenosis at intermediate surgical risk.

In a PMA supplement approved on August 16, 2019 (P130021/058), the FDA expanded FDA approval of the Medtronic CoreValve™ Evolut™ R System and Medtronic CoreValve™ Evolut™ Pro System to include patients at low risk for surgical aortic valve replacement. The devices are indicated for relief of aortic stenosis in patients with symptomatic heart disease due to severe native calcific aortic stenosis who are judged by a heart team, including a cardiac surgeon, to be appropriate for the transcatheter heart valve replacement therapy. Data from the Evolut Surgical Replacement and Transcatheter Valve Implantation in Low Risk Patients Trial (Popma, et al., 2019) was the basis for the PMA approval decision (NCT NCT02701283).

In a PMA supplement approved on September 19, 2019 (P130021/059), the FDA approved modifications to the CoreValve Evolut PRO System. The device, as modified, will be marketed under the trade name Evolut PRO+ System.

**Literature Review—Transcatheter Aortic Valve Implantation in High Risk Patients:**

TAVR is well established for the treatment of high-risk and inoperable patients with symptomatic severe aortic stenosis. A robust evidence base has compared transcatheter aortic valve replacement (TAVR) to the standard of care for aortic stenosis. The series of Placement of AoRTic TraNsCatheTER Valves (PARTNER) trials began with PARTNER 1B (n=358), which demonstrated superiority of TAVR to medical therapy in inoperable patients,
with an absolute survival advantage of 23% at five years (Leon, et al., 2010). The PARTNER 1A (n=699) and CoreValve (n=795) trials randomized high–surgical risk patients between TAVR and surgical aortic valve replacement (SAVR) (Smith, et al., 2011; Adams, et al., 2014). Both trials were noninferiority trials and showed either no difference or improved survival with TAVR at one year. Patients in PARTNER 1A have been followed to five years with no survival difference seen (Mack, et al., 2015) (Arshi, et al., 2019; Herrmann, et al., 2019; Pibarot, et al., 2019; Kapadia, et al., 2015).

Literature Review–Transcatheter Aortic Valve Implantation in Intermediate Risk Patients:
Two multicenter randomized controlled studies have compared TAVR to surgical aortic valve replacement (SAVR) in symptomatic patients at intermediate surgical risk. The PARTNER 2A trial (Leon, et al., 2016) randomized 2032 patients to the balloon-expandable Sapien valve versus SAVR, and the SURTAVI trial (Reardon, et al., 2017) randomized 1660 patients to a self-expanding TAVR (CoreValve or Evolut-R) versus SAVR. The results of both trials demonstrated noninferiority of TAVR to SAVR for the composite endpoint of death and stroke at two years. In a large registry of symptomatic, intermediate-risk patients who underwent TAVR using the balloon-expandable Sapien 3 system (Thourani, et al., 2016), survival was markedly superior to the surgical arm of the PARTNER 2A study (Herrmann et al., 2019).

Literature Review–Transcatheter Aortic Valve Implantation in Low Risk Patients:
Two recent randomized clinical trials (RCTs) reported favorable short-term results with TAVR in low-risk patients (Popma, et al., 2019; Mack, et al., 2019). The Evolut Low Risk Trial (Popma, et al., 2019) reported the estimated two year incidence of the primary endpoint, a composite of death or disabling stroke, was 5.3% in the TAVI group and 6.7% in the SAVR group showing non-inferiority of TAVI and SAVR, but no superiority for either mortality or stroke at one year. The PARTNER 3 Trial (Mack, et al., 2019) The PARTNER 3 low risk study showed superiority of TAVI for stroke and the composite primary endpoint of death, stroke and rehospitalization at one year. The Nordic Aortic Valve Intervention Trial (NOTION) (Thyregod, et al., 2019) randomized patients to receive TAVR or SAVR, and 82% of the patients were at low risk for surgical operations (i.e., Society of Thoracic Surgeons Predicted Risk of Mortality [STS-PROM] score less than 4%). Similar outcomes were achieved in both TAVR and SAVR treatment arms at five years. A 2018 prospective study by Wakesman et al. reported that transfemoral TAVR, using mainly a third-generation balloon-expandable TAVR device, was associated with no deaths at 30 days compared with 1.7% in a historical, propensity-matched SAVR cohort. The risk/benefit profile for periprocedural complications in low risk patients is similar to the overall TAVR population (i.e., reduction in acute kidney injury and bleeding on the one hand and an increase in pacemaker implantation and vascular complications) (Overtochouk, et al., 2019). The 2017 focused update to the 2014 American College of Cardiology (ACC) and American Heart Association (AHA) Practice Guideline for the Management of Patients with Valvular Heart Disease recommends surgical aortic valve replacement for low surgical risk patients (Nishimura, et al., 2014, 2017). Long-term follow-up data on outcomes and valve durability is needed.

Evolut Surgical Replacement and Transcatheter Valve Implantation in Low Risk Patients: In the Evolut Low Risk randomized controlled noninferiority trial, Popma et al. (2019) reported the safety and efficacy of transcatheter aortic valve implantation (TAVI) in patients with aortic stenosis with low surgical risk. The as-treated cohort included 1403 patients. Patients were randomly assigned to TAVI with one of three Medtronic self-expanding valves (i.e., CoreValve, Evolut R, or Evolut Pro) (n=725) or surgical aortic valve replacement (n=678). Eligible patients had severe aortic-valve stenosis with suitable anatomy for TAVR or surgery and no more than a predicted 3% risk of death by 30 days of surgery, as assessed by a local heart team. The patients’ mean age was 74. Patients were evaluated at one, six, 12, 18 and 24 months after the procedure. At the pre-specified interim analysis, 12-month follow-up was available for 432 patients in the TAVR group and 352 in the surgery group; 24-month follow-up was available for 72 patients in the TAVR group and 65 patients in the surgery group. The median follow-up time in each group was 12.2 months. The estimated incidence of the primary endpoint, a composite of death or disabling stroke at two years, was 5.3% in the TAVI group and 6.7% in the surgery group meeting the noninferiority threshold. At 24 months, death from any cause was 4.5% for the TAVR group and 4.5% for the SAVR group and the incidence of disabling stroke was 1.1% for TAVR and 3.5% for SAVR. At 30 days, the TAVI group had significantly lower incidences of disabling stroke (0.5% vs. 1.7%), bleeding complications (2.4% vs. 7.5%), acute kidney injury (0.9% vs. 2.8%), and atrial fibrillation (7.7% vs. 35.4%) but higher rates of moderate or severe aortic regurgitation (3.5% vs. 0.5%) and permanent pacemaker implantation (17.4% vs. 6.1%). Mortality rates were not significantly different (0.5% vs. 1.3%). Incidences of stroke, prosthetic-valve thrombosis, endocarditis, and reintervention were similar in the two groups at one year. At one
Follow-up is needed to compare outcomes between TAVI and surgical aortic valve replacement (ClinicalTrials.gov were similar in the two groups (1.0% vs. 2.5%). This study is limited by short-term one year outcomes. Long-term severe paravalvular regurgitation (0.6% vs. 0.5%) were similar in the TAVI and surgery groups. Mortality rates (0.4% vs. 1.1%). At one year, prosthetic valve mean gradients (13.7% vs. 11.6%) and frequency of moderate or severe paravalvular regurgitation (0.8% vs. 0.0%). Mortality rates were not significantly different.

There were no significant differences in the frequency of permanent pacemaker insertions (6.6% vs. 4.1%) or leak at 30 days. Fourteen percent of TAVR patients had evidence of subclinical leaflet thrombosis at 30 days. Fourteen percent of TAVR patients had evidence of subclinical leaflet thrombosis at 30 days. Endocarditis. Of the 14% of TAVR subjects who had evidence of hypoattenuated leaflet thickening at 30 days, there was no impact on valve hemodynamics at one year, but the stroke rate was numerically higher (3.8% vs. 1.9%). The STS database does not capture any data beyond 30 days, so it is not possible to perform a comparison of TAVR versus SAVR outcomes beyond 30 days (Waksman, et al., 2019). This study is limited by short-term follow-up and study design. Long-term follow-up is needed to evaluate durability of TAVR devices in low-risk patients with symptomatic, severe aortic stenosis (ClinicalTrials.gov number, NCT02628899).

Waksman et al. (2018) reported results from the multi-center Low Risk TAVR (Feasibility of Transcatheter Aortic Valve Replacement in Low-Risk Patients with Symptomatic, Severe Aortic Stenosis) trial. This is the first U.S. FDA-approved Investigational Device Exemption trial to enroll in the United States. This trial is a prospective, unblinded comparison to historical controls from the Society of Thoracic Surgeons (STS) database. The authors enrolled 200 low-risk patients with symptomatic severe aortic stenosis to undergo TAVR. The authors compared outcomes with an inverse probability weighting—adjusted control cohort of 719 patients who underwent SAVR at the same institutions using the STS database. Patients were confirmed to be low risk based on an STS-PROM score ≤3% and absence of comorbidity that would increase surgical risk. Severe aortic stenosis was defined as a mean aortic valve gradient ≥40 mm Hg or Vmax ≥4 m/s and calculated aortic valve area ≤1.0 cm² or aortic valve area index ≤0.6 cm²/m². Only patients who were symptomatic with dyspnea (New York Heart Association [NYHA] functional class II or higher), angina pectoris, or cardiac syncope were included. Patients with unrevascularized coronary artery disease or requiring intervention for another heart valve were excluded. Patients with bicuspid aortic stenosis were excluded and enrolled in a separate registry arm of the trial that is not part of this analysis. The primary endpoint was all cause mortality at 30 days. At 30 days, there was zero all-cause mortality in the TAVR group versus 1.7% mortality in the SAVR group. There was zero in-hospital stroke rate in the TAVR group versus 0.6% stroke in the SAVR group. Permanent pacemaker implantation rates were similar between TAVR and SAVR (5.0% vs. 4.5%). The rates of new-onset atrial fibrillation (3.0%) and length of stay (2.0±1.1 days) were low in the TAVR group. One patient (0.5%) in the TAVR group had >mild paravalvular leak at 30 days. Fourteen percent of TAVR patients had evidence of subclinical leaflet thrombosis at 30 days (Waksman, et al., 2018). At one year follow-up for TAVR, mortality was 3.0%, stroke rate was 2.1%, and permanent pacemaker implantation rate was 7.3%. Two (1.0%) subjects underwent surgical reintervention for endocarditis. Of the 14% of TAVR subjects who had evidence of hypoattenuated leaflet thickening at 30 days, there was no impact on valve hemodynamics at one year, but the stroke rate was numerically higher (3.8% vs. 1.9%).
**Nordic Aortic Valve Intervention (NOTION) trial:** Thyregod et al. (2019) reported findings from the NOTION multicenter, nonblinded, superiority trial comparing TAVR with SAVR in patients ≥70 years old with isolated severe aortic valve stenosis. Clinical and echocardiographic outcomes are reported after five years. Patients were enrolled at three Nordic centers and randomized 1:1 (n=280) to TAVR using the self-expanding CoreValve prosthesis (n=145) or SAVR using any stented bioprostheses (n=135). There were no significant baseline differences between patients in the intention-to-treat groups. Inclusion criteria included isolated severe aortic valve stenosis. The majority of patients had a STS-PROM score below 4% and were considered as surgical low-risk patients. The mean Society of Thoracic Surgeons Predicted Risk of Mortality score was 3.0%±1.7%. The major exclusion criteria included need for acute treatment, severe coronary artery disease, severe nonaortic valvular disease, prior heart surgery, recent stroke or myocardial infarction (MI), or severe lung or renal disease.

The primary composite outcome was the rate of all-cause mortality, stroke, or myocardial infarction. The baseline characteristics were similar. The primary composite outcome of all-cause mortality, stroke, or MI at both 30 days and one year was not statistically different between TAVR and SAVR groups and remained not different between groups at five years with 38.0% for TAVR and 36.3% for SAVR. TAVR patients had larger prosthetic valve area (1.7 cm² vs 1.2 cm²) with a lower mean transprosthetic gradient (8.2 mm Hg vs 13.7 mm Hg), both unchanged over time. More TAVR patients had moderate/severe total aortic regurgitation (8.2% vs 0.0%) and a new pacemaker (43.7% vs 8.7%). Four patients had prosthetic reintervention and no difference was found for functional outcomes. Although the NOTION trial indicates that TAVR could be a safe treatment alternative in patients with isolated severe aortic valve stenosis and at lower surgical risk, larger scale clinical trials and long-term follow-up are needed to confirm these findings (ClinicalTrials.gov number NCT01057173).

Kolte, et al. (2019) conducted a meta-analysis including four randomized controlled trials (RCTs) (n=2887) of TAVR versus surgical aortic valve replacement (SAVR) in patients who are at low surgical risk (1497 to TAVR and 1390 to SAVR). Follow-up was one year. The primary outcome was all-cause death at one year. At one year, compared with SAVR, TAVR was associated with significantly lower risk of: all-cause death (2.1% vs. 3.5%; p=0.03) and cardiovascular death (1.6% vs. 2.9%; p=0.02). Rates of new/worsening atrial fibrillation, life-threatening/disabling bleeding, and acute kidney injury stage 2/3 were lower, although permanent pacemaker implantation and moderate/severe paravalvular leak were higher after TAVR versus SAVR. There were no significant differences between TAVR versus SAVR for major vascular complications, endocarditis, aortic valve re-intervention, and New York Heart Association functional class ≥II. These one year follow-up findings are complementary to the recent pivotal RCTs suggesting that TAVR may be the preferred option over SAVR in low-risk patients with severe AS who are candidates for bioprosthetic AVR. Long-term follow-up data on outcomes and valve durability is needed.

Bekeredjian et al. (2019) reported the study endpoint of in-hospital, 30-day, and 1-year survival in a prospective registry analysis comparing TAVI patients with SAVR patients in a low surgical risk cohort. The study included patients with Society of Thoracic Surgeons Score of <4%. A total of 20549 low surgical risk patients, comprising 14487 surgical patients and 6062 TAVI patients were included in the study. transcatheter aortic valve implantation patients showed a significantly higher in-hospital and 30-day survival than SAVR patients (in hospital survival TAVI vs. SAVR: 98.5% vs. 97.3%; p=0.003; 30-day survival TAVI vs. SAVR: 98.1% vs. 97.1%; p=0.014). At one year, survival rates did not differ significantly (survival TAVI vs. SAVR: 90.0% vs. 91.2%; p=0.158). This study is limited by its non-randomized design, being a large, prospective, and all-comers registry.

Witberg et al. (2018) conducted a systematic review and meta-analysis of RCTs and observational studies with propensity score matching (PSM) of TAVR versus surgical aortic valve replacement (SAVR) in patients who are at low surgical risk. The primary outcome was all-cause mortality. The secondary outcomes included stroke, myocardial infarction, bleeding, and various procedural complications. Six studies, two RCTs (n=350) and four observational PSM studies (n=3134), totaling 3484 patients were included. Three of the studies specifically included patients who were only at low surgical risk, while the other three studies included patients at low–intermediate surgical risk, but their mean value was in the low risk category. Follow-up ranged from three months to three years (median 2 years). The short-term 30 day mortality was similar with TAVR or SAVR (2.2% for TAVR and 2.6% for SAVR). TAVR was associated with an increased risk for intermediate-term two year mortality (17.2% for TAVR and 12.7% for SAVR). In terms of periprocedural complications, TAVR was associated with reduced risk for bleeding and renal failure and an increase in vascular complications and pacemaker implantation. Although there is no difference in short-term mortality between TAVR/SAVR, TAVR was associated with an increased risk for intermediate, median 2 years, term mortality. The risk/benefit profile for periprocedural
complications in low risk patients is similar to the overall TAVR population (i.e., reduction in acute kidney injury and bleeding on the one hand and an increase in pacemaker implantation and vascular complications). This meta-analysis did not include data from the Partner 3 and Medtronic Transcatheter Aortic Valve Replacement in Low Risk Patients RCTs.

In a meta-analysis, Arora et al. (2017) compared the 30-day risk of clinical outcomes between TAVR and SAVR in the lower surgical risk population. Studies were included if the overall mean Society of Thoracic Surgeons Score was < 4% (or equivalent Euroscore). A total of four studies, including one clinical trial and three propensity-matched cohort studies met the inclusion criteria (n=2252). The authors reported that TAVR patients had lower risk of 30 day mortality and strokes but lacked the power to obtain statistical significance. TAVR patients were also less likely to have bleeding complications acute kidney injury, and were more likely to have vascular complications, paravalvular regurgitation and need for pacemaker implantations. Among lower risk patients, TAVR and SAVR appear to be comparable in short term outcomes. Additional long-term studies comparing TAVR and SAVR in low risk patients are needed.

Hayes Medical Technology Report
The September 2018 Hayes Medical Technology Directory Comparative Effectiveness Review Transcatheter Aortic Valve Implantation (TAVI) and Surgical Aortic Valve Replacement (SAVR) for Aortic Stenosis in Low Risk Patients reports on the use of primary TAVI to treat severe calcific aortic stenosis (AS) in patients at low or intermediate surgical risk for complications with open SAVR, and who have not undergone prior SAVR or TAVI. To accommodate a large body of literature, a Review of Reviews methodology was adopted for this report. A systematic search identified one systematic review (SR) by Witberg et al. (2018) which included two randomized controlled trials (RCTs) and four propensity score-matched observational studies (PMOS) comparing TAVI with SAVR in low-risk patients and one SR in intermediate-risk patients by Lazkani et al. (2018) which included four RCTs, one case-controlled study and six cohort studies. One subsequently published propensity score-matched observational study in intermediate-risk patients was also identified (Thourani, et al., 2016). The authors concluded that “For treatment of severe calcific AS in patients with intermediate surgical risk for complications during open valve replacement, TAVI may be a suitable alternative to SAVR in patients for whom a dedicated heart team determines it is appropriate in consideration of presurgical assessment as described in clinical practice guidelines. Moderate-quality evidence indicates mortality, stroke, and myocardial infarction are not significantly different in intermediate-risk patients treated with TAVI or SAVR at follow-up of at least two years. Further, evidence indicates that the incidence of acute kidney injury and atrial fibrillation are lower after TAVI than after SAVR. However, new pacemaker implantation, vascular complications, and aortic insufficiency are higher after TAVI than after SAVR. Additional well-designed RCTs that provide data regarding the long-term durability and safety of TAVI are needed. For treatment of patients with severe calcific AS in patients with low surgical risk for complications during open surgical valve replacement, the available evidence of moderate quality indicates a higher incidence of mortality after TAVI than SAVR at one to three years follow-up” (Hayes, 2018; annual review 2019).

Transcatheter Aortic Valve Implantation (TAVI) for Treatment of a Failed Surgical Bioprosthesis (TAV-in-SAV): In recent years, several reports have suggested that the use of transcatheter aortic valve replacement (TAVR) within failed surgically inserted bioprosthetic valves (valve-in-valve [VIV]) is technically feasible. The largest case series published to date is from the Global Valve-in-Valve registry which is the known as the Medtronic CoreValve U.S. Expanded Use Post Approval Study TAV in SAV (Dvir, et al., 2012). This study included 202 patients from 38 cardiac centers with a prior surgical bioprosthetic valve replacement that had failed. Bioprosthesis mode of failure was stenosis (n=85; 42%), regurgitation (n=68; 34%), or combined stenosis and regurgitation (n=49; 24%). Implanted devices included CoreValve (n=124) and Edwards SAPIEN (n=78). Successful VIV implantation was defined as a procedure having all of the following: successful vascular access, delivery, and deployment of a device; successful retrieval of the delivery system; intended performance of the device with neither severe stenosis (mean aortic gradient >40 mm Hg or peak velocity >4 m/s) nor moderate or severe regurgitation; and the patient being transferred alive out of the catheterization suite. After the procedure, valve maximum/mean gradients were 28.4±14.1/15.9±8.6 mm Hg. The procedure was successful in 93.1% of attempts, and 95% of patients had one degree or less of aortic regurgitation post-procedure. Adverse procedural outcomes included initial device malposition in 15.3% of cases and ostial coronary obstruction in 3.5%. Overall mortality was 8.4% at 30 days and 16.3% at one year. At 30 days follow-up, 84.1% of patients were in NYHA functional Class I or II. One year follow-up was obtained in 87 patients, with 85.8% survival of treated patients.
The authors report that “a randomized controlled trial comparing reoperative SAVR and VIV in patients with failed bioprostheses has never been executed, and because VIV treatment is still infrequent, it will be quite difficult to conduct such a trial. As a result, there are not enough data to justify VIV instead of reoperation in most high-risk patients with failed aortic bioprostheses. Nevertheless, VIV could be an acceptable approach in carefully selected high-risk patients and in those considered as having no option (i.e., those with no other effective treatment option for their illness)”.

Using Valve-in-Valve International Data (VIVID) registry data, Dvir et al. (2014) determined the survival of patients after transcatheter ViV implantation inside failed surgical bioprosthesis valves. Correlates for survival were evaluated using a multinational registry that included 459 patients with degenerated bioprosthetic valves undergoing ViV implantation. Modes of bioprostheses failure were stenosis (n=181), regurgitation (n=139) and combined (n=139). The stenosis group had a higher percentage of small valves (37% vs 20.9% and 26.6% in the regurgitation and combined groups, respectively). Within one month following ViV implantation, 35 (7.6%) patients died, eight (1.7%) had major stroke and 313 (92.6%) of surviving patients had good functional status (NYHA class I/II). The overall one year survival rate was 83.2%; 62 death events; 228 survivors). Patients in the stenosis group had worse one year survival (76.6%; 34 deaths; 86 survivors) in comparison with the regurgitation group (91.2%; 10 deaths; 76 survivors) and the combined group (83.9%; 18 deaths; 66 survivors). Similarly, patients with small valves had worse one year survival (74.8%; 27 deaths; 57 survivors) versus with intermediate-sized valves (81.8%; 26 deaths; 92 survivors) and with large valves (93.3%; 7 deaths; 73 survivors). Factors associated with mortality within one year included having small surgical bioprosthesis (≤21 mm) and baseline stenosis (vs regurgitation).

Deeb et al. (2017) evaluated the safety and effectiveness of self-expanding transcatheter aortic valve replacement (TAVR) in patients with surgical valve failure (SVF). The CoreValve U.S. Expanded Use Study was a prospective, nonrandomized study that enrolled 233 patients with symptomatic SVF who were deemed unsuitable for reoperation. Patients were treated with self-expanding TAVR and evaluated for 30-day and one year outcomes after the procedure. SVF occurred through stenosis (56.4%), regurgitation (22.0%), or a combination (21.6%). A total of 227 patients underwent attempted TAVR and successful TAVR was achieved in 225 (99.1%) patients. Patients were elderly (76.7±10.8 years), had a Society of Thoracic Surgeons Predicted Risk of Mortality score of 9.0± 6.7%, and were severely symptomatic (86.8% New York Heart Association functional class III or IV). The all-cause mortality rate was 2.2% at 30 days and 14.6% at one year; major stroke rate was 0.4% at 30 days and 1.8% at one year. Moderate aortic regurgitation occurred in 3.5% of patients at 30 days and 7.4% of patients at one year, with no severe aortic regurgitation. The rate of new permanent pacemaker implantation was 8.1% at 30 days and 11.0% at one year. The mean valve gradient was 17.0± 8.8 mm Hg at 30 days and 16.± 8.9 mm Hg at one year. Factors significantly associated with higher discharge mean aortic gradients were surgical valve size, stenosis as modality of SVF, and presence of surgical valve prosthesis patient mismatch (all p< 0.001). This study was not a randomized trial, and no comparisons were pre-specified. Due to a relatively low number of patients in the study, subgroup analyses were somewhat limited. Longer-term follow-up is needed to determine the impact of the higher residual mean value gradients.

Webb et al. (2017) evaluated 30-day and one year outcomes in high-risk patients undergoing ViV TAVR using the SAPIEN XT valve. Patients with symptomatic degeneration of surgical aortic bioprostheses at high risk (≥50% major morbidity or mortality) for reoperative surgery were prospectively enrolled in the multicenter PARTNER 2 ViV trial and continued access registries. ViV procedures were performed in 365 patients (96 initial registry, 269 continued access patients). Mean age was 78.9 ± 10.2 years, and mean STS score was 9.1 ± 4.7%. At 30 days, all-cause mortality was 2.7%, stroke was 2.7%, major vascular complication was 4.1%, conversion to surgery was 0.6%, coronary occlusion was 0.8% and new pacemaker insertion was 1.9%. One year all-cause mortality was 12.4%. Mortality fell from the initial registry to the subsequent continued access registry, both at 30 days (8.2% vs. 0.7%, respectively) and at 1 year (19.7% vs. 9.8%, respectively). At 1 year, mean gradient was 17.6 mmHg, and effective orifice area was 1.16 cm2, with greater than mild paravalvular regurgitation of 1.9%. Left ventricular ejection fraction increased (50.6% to 54.2%), and mass index decreased (135.7 to 117.6 g/m2), with reductions in both mitral (34.9% vs. 12.7%) and tricuspid (31.8% vs. 21.2%) moderate or severe regurgitation. Study limitations include lack of randomization and control and short-term follow-up.
Gozdek et al. (2018) performed a systematic review and meta-analysis to directly compare redo surgical aortic valve replacement (re-sAVR) with valve-in-valve transcatheter aortic valve implantation (ViV TAVI) for patients with failed degenerated aortic bioprostheses. Multiple databases were screened for all available reports comparing ViV TAVI with re-sAVR in patients with failing degenerated aortic bioprostheses. The primary outcome was all-cause mortality determined from the longest available survival data. Five observational studies (n=342) were included in the meta-analysis; patients in the ViV TAVI group were older and had a higher baseline risk compared to those in the re-sAVR group. Although there was no statistical difference in procedural mortality, 30-day mortality and cardiovascular mortality at a mean follow-up period of 18 months, cumulative survival analysis favored surgery with borderline statistical significance (p=0.039). ViV TAVI was associated with a significantly lower rate of permanent pacemaker implantations (p= 0.002) and shorter intensive care unit (p=0.001) and hospital stays (p=0.020). In contrast, re-sAVR offered superior echocardiographic outcomes: lower incidence of patient–prosthesis mismatch (p=0.008), fewer paravalvular leaks (p=0.023) and lower mean postoperative aortic valve gradients in the prespecified analysis (p=0.017). The authors reported that the ViV TAVI approach is a safe and feasible alternative to re-sAVR that may offer an effective, less invasive treatment for patients with failed surgical aortic valve bioprostheses who are inoperable or at high risk. Re-sAVR should remain the standard of care, particularly in the low-risk population, because it offers superior hemodynamic outcomes with low mortality rates.

Phan et al. (2016) performed a systematic review to compare outcomes of transcatheter valve-in-valve (ViV) implantation for degenerated aortic bioprostheses to redo conventional aortic valve replacement (cAVR). A total of 18 retrospective and prospective studies (n=823) were included. Pooled analysis demonstrated ViV achieved significant improvements in mean gradient (38 mmHg preoperatively to 15.2 mmHg postoperatively, p<0.001) and peak gradient (59.2 to 23.2 mmHg, p=0.0003). These improvements were similar to the outcomes achieved by cAVR. The incidence of moderate paravalvular leaks (PVL) were significantly higher for ViV compared to cAVR (3.3% vs 0.4%, p=0.022). In terms of morbidity, ViV had a significantly lower incidence of stroke (1.9% vs 8.8%, p=0.002) and bleeding (6.9% vs 9.1%, p=0.014) compared to redo cAVR. Perioperative mortality rates were similar for ViV (7.9%) and redo cAVR (6.1%, p=0.35). The authors concluded that transcatheter ViV implantation achieves similar hemodynamic outcomes, with lower risk of strokes and bleeding but higher PVL rates compared to redo cAVR. Additional randomized studies and prospective registries are needed to compare the effectiveness of transcatheter ViV with cAVR, and clarify the rates of PVLs.

Raval et al. (2014) performed a systematic review to evaluate the effectiveness and outcomes of ViV implantation using transcatheter heart valves in aortic, mitral, pulmonary, tricuspid positions. Sixty-one studies were included: aortic (n=31), mitral (n=13), tricuspid (n=12) and pure native aortic valve regurgitation (n=9). The authors reported that ViV implantation can be considered an acceptable alternative to conventional open heart surgery for elderly high-risk surgical patients with bioprosthetic degeneration; however, most of the studies included were case reports with some case series. The authors reported that long-term follow-up of treated patients will be necessary to establish the true role of ViV implantation for bioprosthetic degeneration.

Professional Societies/Organizations: The 2017 focused update to the 2014 American College of Cardiology (ACC) and American Heart Association (AHA) Practice Guideline for the Management of Patients with Valvular Heart Disease has the following recommendations for surgical or transcatheter AVR (TAVR) (Nishimura, et al., 2014, 2017). Guideline recommendations are classified as Class I (Strong), Class Ila (Moderate), Class Iib (Weak), Class III (No Benefit: Moderate) and Class III (Harm: Strong). For each Class the Guideline identified suggested phrases for writing recommendations. The classification system is described as follows:

Class I (Strong): Benefit >>>Risk; Suggested phrases for writing recommendations:
- Is recommended
- Is indicated/useful/effective/beneficial
- Should be performed/administered/other
- Comparative Effectiveness Phrases†:
  - Treatment/strategy A is recommended/indicated in preference to treatment B
  - Treatment A should be chosen over treatment B

Class Ila (Moderate): Benefit >> Risk; Suggested phrases for writing recommendations:
- Is reasonable
- Can be useful/effective/beneficial
Comparative Effectiveness Phrases†:
- Treatment/strategy A is probably recommended/indicated in preference to treatment B
- It is reasonable to choose treatment A over treatment B

Class IIb (Weak): Benefit ≥ Risk; Suggested phrases for writing recommendations:
- May/might be reasonable
- May/might be considered
- Usefulness/effectiveness is unknown/unclear/uncertain or not well established

Class III: No Benefit (Moderate) Benefit=Risk; (Generally Level of evidence (LOE) A or B use only). Suggested phrases for writing recommendations:
- Is not recommended
- Is not indicated/useful/effective/beneficial
- Should not be performed/administered/other

Class III: Harm (Strong): Risk > Benefit; Suggested phrases for writing recommendations:
- Potentially harmful
- Causes harm
- Associated with excess morbidity/mortality
- Should not be performed/administered/other

The Level (Quality) of Evidence supporting each recommendation is classified as follows:

Level A:
- High quality evidence‡ from more than 1 RCT
- Meta-analyses of high-quality RCTs
- One or more RCTs corroborated by high-quality registry studies

Level B-R: (Randomized)
- Moderate-quality evidence‡ from 1 or more RCTs
- Meta-analyses of moderate-quality RCTs

Level B-NR: (Nonrandomized)
- Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies
- Meta-analyses of such studies

Level C-LD: (Limited Data)
- Randomized studies or nonrandomized observational or registry studies with limitations of design or execution
- Meta-analyses of such studies
- Physiological or mechanistic studies in human subjects

Level C-LD: (Expert Opinion): Consensus of expert opinion based on clinical experience

COR and LOE are determined independently (any COR may be paired with any LOE).

A recommendation with LOE C does not imply that the recommendation is weak. Many important clinical questions addressed in guidelines do not lend themselves to clinical trials. Although RCTs are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

†For comparative-effectiveness recommendations (COR I and IIa; LOE A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

‡ The method of assessing quality is evolving, including the application of standardized, widely used, and preferably validated evidence grading tools; and for systematic reviews, the incorporation of an Evidence Review Committee.

The following recommendations for surgical or transcatheter AVR and prosthetic valve stenosis are included in the 2017 focused update to the 2014 guideline:
Class I
- For patients in whom TAVR or high-risk surgical AVR is being considered, a Heart Valve Team consisting of an integrated, multidisciplinary group of healthcare professionals with expertise in valvular heart disease, cardiac imaging, interventional cardiology, cardiac anesthesia, and cardiac surgery should collaborate to provide optimal patient care. (Level of Evidence: C)

Class I
- Surgical AVR is recommended for symptomatic patients with severe AS (Stage D) and asymptomatic patients with severe AS (Stage C) who meet an indication for AVR when surgical risk is low or intermediate. (Level of Evidence: B-NR)

Class I
- TAVR is recommended for symptomatic patients with severe AS (Stage D) and a prohibitive risk for surgical AVR who have predicted post-TAVR survival greater than 12 months. (Level of Evidence: A)

Class I
- Surgical AVR or TAVR is recommended for symptomatic patients with severe AS (Stage D) and high risk for surgical AVR, depending on patient-specific procedural risks, values, and preferences. (Level of Evidence: A)

Class IIa:
- TAVR is a reasonable alternative to surgical AVR for symptomatic patients with severe AS (Stage D) and an intermediate surgical risk, depending on patient-specific procedural risks, values, and preferences. (Level of Evidence: B-R)
- For severely symptomatic patients with bioprosthetic aortic valve stenosis judged by the heart team to be at high or prohibitive risk of reoperation, and in whom improvement in hemodynamics is anticipated, a transcatheter valve-in-valve procedure is reasonable. (Level of Evidence: B-NR)

Class IIb:
- Percutaneous aortic balloon dilation may be considered as a bridge to surgical AVR or TAVR for symptomatic patients with severe AS. (Level of Evidence: C)

Class III: No Benefit
- TAVR is not recommended in patients in whom existing comorbidities would preclude the expected benefit from correction of AS. (Level of Evidence: B)

An ACCF/AATS/SCAI/STS Expert Consensus Document on Transcatheter Aortic Valve Replacement (TAVR) (Holmes et al., 2012) was published with involvement of twelve professional societies to examine the current state of the evidence, facilitate integration of this technology as one of the available therapeutic options for patients with aortic valvular stenosis, and enable responsible adoption and diffusion of this promising technology. The authors note that the document is focused on published data; but there is a single completed randomized trial, although others are in progress or planned. Much of the data is therefore based upon information from studies and registries, which are frequently retrospective and include self-reported clinical events rather than adjudicated events.

The expert consensus document states that TAVR offers new and potentially transformational technology for patients with severe aortic valvular stenosis who are either extremely high-risk candidates or inoperable for surgical aortic valve replacement (AVR) or who are inoperable due to associated comorbidities. In the future, this technology may be utilized in lower risk surgical candidates.

The consensus document summarizes current recommendations for treatment of patients with aortic stenosis, including surgical aortic valve replacement, transcatheter aortic valve replacement, balloon aortic valvuloplasty, and medical therapy (refer to Appendix A, below). The document provides the following observations and recommendations regarding transcatheter aortic valve replacement:

- Complex Technology: Although the technique and equipment continue to evolve, TAVR is a complex procedure with many interlocking steps that require meticulous attention to achieve optimal results and minimize complications.
• **Team-Based Approach:** A foundational requirement of TAVR is a team-based approach to patient care. Given the high-risk profile of patients, who often have multiple comorbidities, as well as the technical complexity of the procedure involved, this team-based care will need to include multiple contributors at different stages in the process but will be mainly centered around the primary cardiologist, the cardiovascular surgeon, and the interventional cardiologist. Patients and families must be included in the care team. Other team members will include cardiac anesthesiologists, heart failure specialists, structural heart disease physicians, imaging specialists and the nursing care team, among others.

• **Patient Selection:** In adults with severe, symptomatic, calcific stenosis of a trileaflet aortic valve who have aortic and vascular anatomy suitable for transcatheter aortic valve replacement (TAVR) and a predicted survival >12 months:
  - TAVR is recommended in patients with prohibitive surgical risk.
  - TAVR is a reasonable alternative to surgical aortic valve replacement (AVR) in patients at high surgical risk

Prohibitive surgical risk is defined as:
• An estimated 50% or greater risk of mortality or irreversible morbidity at 30 days (as assessed by one cardiologist and two cardiothoracic surgeons), or other factors such as frailty, prior radiation therapy, porcelain aorta, and severe hepatic or pulmonary disease.

Suitable aortic and vascular anatomy is defined as:
• Both aortic annulus size and valve plane to coronary ostium height suitable for placement of an available TAVR.
• Adequate vascular access for passage of the TAVR system (femoral iliac, subclavian, axillary) or suitability for an apical implantation approach.

TAVR is not currently recommended because of limited available information in adults who have:
• An acceptable surgical risk for conventional surgical aortic valve replacement
• Known bicuspid aortic valve
• Failing bioprosthetic aortic valve
• Severe mitral annular calcification or severe mitral regurgitation
• Moderate aortic stenosis
• Other (e.g., severe aortic regurgitation and subaortic stenosis)

In the above groups, additional scientific data will need to be collected to ascertain risk/benefit ratio prior to integration into routine clinical care.

**Summary—Transcatheter Aortic Valve Implantation:** Transcatheter aortic valve implantation (TAVI) also referred to as transcatheter aortic valve replacement (TAVR) has been proposed as a less invasive alternative to conventional surgical valve replacement. Conventional valve replacement requires general anesthesia, a sternotomy, and heart-lung bypass. A significant percentage of patients with severe aortic stenosis are not considered suitable candidates for surgical aortic valve replacement due to the presence of significant comorbidities TAVI may be a reasonable alternative to open heart surgery in carefully selected, low, intermediate or high-risk patients with severe symptomatic aortic stenosis who meet the FDA-specified indications for use.

Evidence in the peer-reviewed literature related to the use of TAVI for valve-in-valve replacement after failed TAVI or degenerated bioprosthetic valve consists primarily of a registry study and case series. There is insufficient evidence in the published medical literature to demonstrate the safety and efficacy of this procedure compared with surgical repair.

**Transcatheter Cerebral Embolic Protection (TCEP) Devices**
Despite the new-generation TAVR devices and increased operator experience, the risk of cerebrovascular events varies from 2.7% to 5.5% at 30 days. Transcatheter cerebral embolic protection (TCEP) is proposed to address the risk of neurological injury during or after TAVR. Several TCEP devices are commercially available outside the U.S. The Sentinel™ Cerebral Protection System (Claret Medical Inc., Santa Rosa, CA) is the first TCEP device to be FDA-approved. The Sentinel Cerebral Protection System (CPS) is a single-use device that filters and collects debris released during TAVR in order to prevent the debris from migrating to the brain. The device contains two independent filters within a single-delivery catheter that is delivered via the right radial artery or brachial artery. The larger proximal filter is deployed in the brachiocephalic trunk, and the smaller distal filter is deployed in the left common carotid artery before TAVR (Gasier, 2018; Hayes, 2018).

U.S. Food and Drug Administration (FDA): The Sentinel™ Cerebral Protection System (Claret Medical Inc., Santa Rosa, CA) received de novo FDA approval on June 1, 2017 (DEN160043) as a Class II medical device. It is indicated for use as an embolic protection device to capture and remove thrombus/debris while performing transcatheter aortic valve replacement procedures. The diameters of the arteries at the site of filter placement should be between 9–15 mm for the brachiocephalic and 6.5–10 mm in the left common carotid.

**Literature Review:** In two randomized, controlled trials (Kapadia, et al., 2017; Van Mieghem, et al., 2016), the primary efficacy endpoint was reduction in volume of new cerebral lesions on diffusion-weighted magnetic resonance imaging (DW-MRI) evaluation up to seven days post-TAVR, a surrogate endpoint for cerebral damage. This endpoint was not met in either trial, although both trials demonstrated a nonsignificant numerical reduction in new cerebral lesions favoring the Sentinel device over no transcatheter cerebral embolic protection. Both trials were limited by small sample sizes and poor compliance with DW-MRI follow-up. Medical textbooks and an UpToDate report do not indicate the use of the Sentinel cerebral protection system or embolic protection devices in association with transcatheter aortic valve replacement to be generally accepted/established or standard of care (Hermann, et al., 2019; Dalby, et al., 2019; Veluz, et al., 2017; Kodali, et al., 2016).

Kapadia et al. (2017) conducted a prospective randomized multicenter controlled trial (SENTINEL RCT) evaluating the safety and efficacy of transcatheter cerebral embolic protection (TCEP) during TAVR. Nineteen centers randomized 363 patients undergoing TAVR to a safety arm (n=123), device imaging (n=121), and control imaging (n=119). The primary safety endpoint consisted of major adverse cardiac and cerebrovascular events (MACCE) at 30 days, and the primary efficacy endpoint was reduction in new lesion volume in protected brain territories on magnetic resonance imaging scans at two to seven days. Patients underwent neurocognitive assessments, and the debris captured was analyzed. The rate of MACCE (7.3%) was noninferior to the performance goal (18.3%, \( p < 0.001 \)) and not statistically different from that of the control group (9.9%; \( p = 0.41 \)). New lesion volume was 178.0 mm³ in control subjects and 102.8 mm³ in the device arm (\( p = 0.33 \)). A post hoc multivariable analysis identified pre-existing lesion volume and valve type as predictors of new lesion volume. Strokes at 30 days were 9.1% in control subjects and 5.6% in patients with devices (\( p = 0.25 \)). Neurocognitive function was similar in control subjects and patients with devices, but there was a correlation between lesion volume and neurocognitive decline (\( p = 0.0022 \)). Debris found within filters in 99% of patients included thrombus, calcification, valve tissue, artery wall, and foreign material. The dual-filter embolism protection device was safely deployed and effective in collecting particulate embolic debris from patients undergoing TAVR, but reduction in cerebral ischemic lesion volume as assessed by MRI was not statistically significant. There were numerous limitations to this study. Follow-up MRI studies were not obtained in 25% of patients from the imaging cohort because of patient noncompliance and the need for new pacemakers post-TAVR. The sample size was too small to assess clinical outcomes and too small to evaluate follow-up MRI findings or neurocognitive outcomes. The use of quantitative MRI analysis as a surrogate endpoint must be further clarified, including stricter time windows for follow-up studies and larger sample sizes. There needs to be a requirement of baseline MRI studies to account for previous lesion volume.

Van Mieghem et al. (2016) conducted a RCT (MISTRAL-C) to assess whether use of the filter-based Sentinel™ Cerebral Protection System (CPS) during transcatheter aortic valve implantation (TAVI) can affect the early incidence of new brain lesions, as assessed by diffusion-weighted magnetic resonance imaging (DW-MRI), and neurocognitive performance. A total of 65 patients were randomized 1:1 to transfemoral TAVI with or without the Sentinel CPS. Patients underwent DW-MRI and extensive neurological examination, including neurocognitive testing one day before and five to seven days after TAVI. Follow-up DW-MRI and neurocognitive testing was completed in 57% and 80%, respectively. New brain lesions were found in 78% of patients with follow-up MRI.
Patients with the Sentinel CPS had numerically fewer new lesions and a smaller total lesion volume (95 mm$^3$ vs. 197 mm$^3$). Overall, 27% of Sentinel CPS patients and 13% of control patients had no new lesions. Ten or more new brain lesions were found only in the control cohort (20% vs. 0% in the Sentinel CPS cohort, p=0.03). Neurocognitive deterioration was present in 4% of patients with Sentinel CPS vs. 27% of patients without (p=0.017). The filters captured debris in all patients with Sentinel CPS protection. This study is limited by the small sample size and underpowered due to a higher than expected MRI drop-out rate. A total of 43% of patients did not complete the follow-up MRI study.

In a prospective study, Seeger et al. (2017) evaluated the impact of cerebral embolic protection on stroke-free survival in 802 patients undergoing TAVR for severe aortic stenosis. The Sentinel cerebral embolic protection device was used in 34.9% (n=280) of consecutive patients. In the remaining group of patients (n=522), TAVR was performed without cerebral embolic protection. Neurological follow-up was done within seven days post-procedure. The primary endpoint was a composite of all-cause mortality or all-stroke within seven days. With use of cerebral embolic protection, the rate of disabling and nondisabling stroke was significantly reduced from 4.6% to 1.4% (p=0.03) in the propensity-matched population (n=560). The primary endpoint occurred significantly less frequently, with 2.1% (n=6 of 280) in the protected group compared with 6.8% (n=19 of 280) in the control group (p=0.01). In patients undergoing TAVR, use of a cerebral embolic protection device demonstrated a significantly higher rate of stroke-free survival compared with unprotected TAVR. This study is limited by lack of randomization.

In the Claret Embolic Protection and TAVI (CLEAN-TAVI) blinded RCT, Haussig et al. (2016) evaluated the effect of a cerebral protection device on the number and volume of cerebral lesions in high risk patients with severe aortic stenosis undergoing TAVR. One hundred patients were randomly assigned to undergo TAVR with a cerebral protection device (filter group; n=50) or without a cerebral protection device (control group; n=50). Brain MRI was performed at baseline, two days and seven days after TAVR. The primary endpoint was the numerical difference in new positive post procedure diffusion-weighted magnetic resonance imaging (DWMRI) brain lesions at two days after TAVI in potentially protected territories. The first hierarchical secondary outcome was the difference in volume of new lesions after TAVI in potentially protected territories. The use of a cerebral protection device reduced the frequency of ischemic cerebral lesions in potentially protected regions. The number of new lesions was 4.00 in the filter group and 10.00 in the control group. New lesion volume after TAVR was 242 mm$^3$ in the filter group and 527 mm$^3$ in the control group. One patient in the control group died prior to the 30-day visit. Life-threatening hemorrhages occurred in one patient in the filter group and one in the control group. Major vascular complications occurred in five patients in the filter group and six patients in the control group. One patient in the filter group and five in the control group had acute kidney injury, and three patients in the filter group had a thoracotomy. Larger studies, with longer follow-up are needed to assess the effect of cerebral protection device use on neurological and cognitive function after TAVR. Clinicaltrials.gov number NCT01833052.

Bagur et al. (2017) performed a systematic review and meta-analysis evaluating the impact of embolic protection devices on cerebrovascular events during TAVR. Sixteen studies involving 1170 patients (865/305 with/without embolic protection devices) were included. Multiple types of embolic protection devices were included. The embolic protection device delivery success rate was reported in all studies and was achieved in 94.5% of patients. Meta-analyses comparing the two methods showed no significant differences between patients undergoing TAVR with or without embolic protection devices with respect to clinically evident stroke and 30-day mortality. Embolic protection during TAVR may be associated with smaller volume of silent ischemic lesions and smaller total volume of silent ischemic lesions. However, it may not reduce the number of new-single, multiple or total number of lesions. There was a high rate of loss to follow-up in most of studies.

Giustino et al. (2016) conducted a systematic review and meta-analysis of four randomized controlled trials (n=252) that tested the safety and efficacy of embolic protection during TAVR. Use of embolic protection was associated with lower total lesion volume and smaller number of new ischemic lesions. Embolic protection was associated with a trend toward lower risk for deterioration in National Institutes of Health Stroke Scale score at discharge and higher Montreal Cognitive Assessment score. Risk for overt stroke and all-cause mortality were nonsignificantly lower in the embolic protection group. The authors noted that the findings are subject to the inherent limitations of the included trials due to study design, length of follow-up, imaging and neurocognitive assessment dropout. Some of the endpoints were not available in all of the included trials. Most of the valves
used were first-generation TAVR devices. Given the substantial limitations of the included studies, the results are only hypothesis generating. Further prospective, adequately powered randomized controlled trials are needed to establish the role of embolic protection during TAVR.

A 2018 Hayes Emerging Technology Report on the Sentinel Cerebral Protection System (CPS) states that in a review of the abstracts retrieved for their report they found mixed outcomes for the use of the Sentinel CPS in patients undergoing TAVR. Reported outcomes suggested that the requested device was safe and captured debris; however, the evidence was insufficient to conclude that use of the device prevented neurocognitive deficits.

Professional Societies/Organizations: A search of the National Guideline Clearinghouse did not identify any guidelines discussing the Sentinel CPS or transcatheter cerebral embolic protection in general.

Pulmonary Valve
In the healthy heart, deoxygenated blood flows from the right ventricle through the right ventricular outflow tract (RVOT), an extension of the ventricular cavity, which connects to the pulmonary artery, from where it enters the lungs. The pulmonary valve lies between the right ventricle and the pulmonary artery. It opens and closes with each heart beat and prevents a backflow of blood. Defects in the RVOT and pulmonary valve impede blood flow from the right ventricle to the lungs.

Congenital heart defects are the most common cause of RVOT and pulmonary valve dysfunction. The most common congenital heart defects affecting the RVOT and pulmonary valve include: tetralogy of Fallot, pulmonary atresia, transposition of the great arteries, and double outlet right ventricle.

Percutaneous pulmonary valve implantation (PPVI), also referred to as transcatheter or catheter-based pulmonary valve implantation or replacement, is a minimally invasive heart surgery in patients with right ventricular outflow tract (RVOT) defects. The procedure involves the deployment and placement of a pulmonary valve prosthesis via a catheter inserted into a vein. The purpose of PPVI is to delay the need for surgical repair of a dysfunctional RVOT. PPVI is proposed to offer minimal invasiveness and avoids cardiopulmonary bypass. The technique is intended to reduce the number of open heart surgeries with their associated risks and complications (Hayes, 2013b).

Presently there are two PPVI systems that are available: the Medtronic Melody® Transcatheter Pulmonary Valve (Medtronic, Inc., Santa Ana, CA) and the Edwards SAPIEN™ XT Transcatheter Heart Valve and Accessories [Edwards Lifesciences, LLC, Irvine, CA].

The Melody device consists of a segment of bovine jugular vein with a thinned down venous wall containing a native, central competent venous valve. This bovine valve is attached to a platinum/iridium stent with a length of 28 mm and diameter of 18 mm that can be crimped to a size of 6 mm and re-expanded up to 22 mm.

The Edwards SAPIEN XT Transcatheter Heart Valve is comprised of a balloon-expandable, radiopaque, cobalt-chromium frame, trileaflet bovine pericardial tissue valve, and polyethylene terephthalate fabric skirt. The NovaFlex+ delivery system is used for delivery of the Edwards SAPIEN XT.

Transcatheter pulmonary valve (TPV) placement was first reported in 2000. Beginning in January 2007, the Melody® TPV (Medtronic, Inc., Santa Ana, CA) was implanted in 150 patients at five US centers under an Investigational Device Exemption (IDE) protocol for treatment of right ventricular outflow tract (RVOT) dysfunction. In January 2010, enrollment in the US Melody Valve IDE trial was completed, and the Melody valve was approved for placement in dysfunctional RVOT conduits as a palliative measure aimed at delaying surgical intervention (McElhinney, et al., 2011). The trial was initially designed to follow patients for five years after implantation or until explantation, but was modified in 2011 to allow follow-up out to 10 years in patients who provided supplemental written informed consent (Cheatham, et al., 2015).

In January 2015 the Melody TPV received Pre-Market Approval (PMA) from the U.S. Food and Drug Administration (FDA) approval based on clinical evidence from three clinical studies that followed patients
implanted with Melody TPV (i.e., the Melody U.S. IDE Study, the Melody U.S. Post Approval Study [PAS] and the European and Canadian Post-Market Surveillance Study [PMSS]).

In February 2016 the SAPIEN XT Transcatheter Heart Valve received Pre-Market Approval (PMA) from the U.S. Food and Drug Administration (FDA) approval based on clinical evidence from the COngenital Multicenter trial of Pulmonic vAlve regurgitation Studying the SAPIEN InterventIONal (COMPASSION) THV trial.

**U.S. Food and Drug Administration (FDA)–Medtronic Melody® Transcatheter Pulmonary Valve (Medtronic, Inc., Santa Ana, CA):** The Medtronic Melody® Transcatheter Pulmonary Valve (Model PB10) and Medtronic Ensemble® Transcatheter Valve Delivery System (NU10). received FDA approval through the Humanitarian Device Exemption (HDE) program on January 25, 2010.

The Melody™ Transcatheter Pulmonary Valve, models PB1016 and PB1018 Ensemble™ Transcatheter Valve Delivery System, models NU1018, NU1020, and NU1022 received FDA approval through the PMA process on January 27, 2015 (P140017). According to the PMA approval order, the Melody Transcatheter Pulmonary Valve is indicated for use as an adjunct to surgery in the management of pediatric and adult patients with the following clinical conditions:

- Existence of a full (circumferential) RVOT conduit that was equal to or greater than 16 mm in diameter when originally implanted and
- Dysfunctional Right Ventricular Outflow Tract (RVOT) conduits with a clinical indication for intervention, and either:
  - regurgitation: ≥ moderate regurgitation, and/or
  - stenosis: mean RVOT gradient ≥ 35 mmHg

Enrollment in the pre-market Investigational Device Exemption (IDE) study was limited to patients who met the following inclusion criteria:

- age ≥ 5 years of old
- weight ≥ 30 kg
- existence of a full (circumferential) RVOT conduit ≥ 16 mm in diameter when originally implanted, or a stented bioprosthesis with a rigid circumferential sewing ring in the RVOT that has an internal diameter ≥ 18 mm and ≤ 22 mm when originally implanted
- Any of the following by transthoracic echocardiography
  - For patients in NYHA Classification II, III, or IV:
    - Moderate (3+) or severe (4+) pulmonary regurgitation, or
    - Mean RVOT gradient ≥ 35 mmHg
  - For patients in NYHA Classification I:
    - Severe (4+) pulmonary regurgitation with RV dilatation (Z-score for tricuspid annular diameter ≥2.0) or dysfunction (RV fractional area change < 40%), or
    - Mean RVOT gradient ≥ 40 mmHg

Patients were not permitted to enroll in the pre-market IDE study if they met any of the following exclusion criteria:

- active endocarditis
- a major or progressive non-cardiac disease (e.g. liver failure, renal failure, cancer) that results in a life expectancy of less than one year
- patient or guardian unwilling or unable to provide written informed consent or comply with follow-up requirements
- obstruction of the central veins (including the superior and inferior vena cava, bilateral iliac veins) such that the delivery system cannot be advanced to the heart via transvenous approach from either femoral vein or internal jugular vein
- positive urine or serum pregnancy test 24 hours prior to procedure in female patients of child bearing potential
- known intravenous drug abuse

On February 24, 2017, approval of the Melody® system was expanded to include patients with a dysfunctional surgical bioprosthetic valve (valve-in-valve). Per the FDA Summary of Effectiveness and Safety Data (SSED), the clinical data supporting the PMA supplemental approval decision were pooled from the following three (3) sources: Melody Transcatheter Pulmonary Valve (TPV) Long-term Follow-up Post Approval Study (PAS) n=8 patients; Melody TPV New Enrollment PAS n=17 patients and Real-World Data n=100 patients.

Edwards SAPIEN™ XT Transcatheter Heart Valve and Accessories [Edwards Lifesciences, LLC, Irvine, CA]: The SAPIEN XT Transcatheter Heart Valve and Accessories received FDA approval through the PMA process on February 29, 2016 (P130009/S037). According to the PMA approval order, this device is indicated for use in pediatric and adult patients with a dysfunctional, non-compliant Right Ventricular Outflow Tract (RVOT) conduit with a clinical indication for intervention and pulmonary regurgitation ≥ moderate and/or mean RVOT gradient ≥ 35 mmHg.

The FDA Summary of Effectiveness and Safety Data (SSED) states that Edwards Lifesciences performed a clinical study to establish a reasonable assurance of safety and effectiveness of pulmonic implantation with the Edwards SAPIEN THV in patients with dysfunctional RVOT conduits in the United States under Investigational Device Exemption (IDE) #G060242 (entitled the COngenital Multicenter trial of Pulmonic vaIve regurgitation Studying the SAPIEN InterventIONal THV, “COMPASSION” trial). Data from this clinical study were the basis for the PMA approval decision.

The 2016 FDA PMA approval states that Edwards agreed to conduct a study to evaluate long-term safety and effectiveness of the SAPIEN XT THV in the pulmonic position for the intended patient population (especially pediatric) when used as indicated with all valve sizes. It is a single-arm, prospective, multicenter post approval study using a performance goal based on the original COMPASSION trial. The study patients are pediatric and adult patients with a dysfunctional, non-compliant right ventricular outflow tract (RVOT) conduit with a clinical indication for intervention and pulmonary regurgitation ≥ moderate and/or mean RVOT gradient ≥ 35 mmHg. The eligibility criteria will be consistent with the final FDA-approved IFU and labeling. A sample size of 162 subjects is required for the hypothesis test on the primary effectiveness endpoint with at least 80% of the power. A total of 191 patients will be enrolled at up to 10 sites in the US to account for loss to follow-up. The patients will be followed at hospital discharge, 30 days, 1 year and annually thereafter through 5 years.

**Literature Review—Transcatheter Pulmonary Valve (TPV) Implantation**

**Melody U.S. IDE Studies:** Cheatham et al. (2015) evaluated the midterm hemodynamic and clinical outcomes in the U.S. Melody Valve IDE trial patients (n=148), who were all at least four years out from Melody valve implantation. The nonrandomized IDE trial prospectively enrolled pediatric and adult patients (median age, 19 years) with right ventricular outflow tract conduit obstruction or regurgitation. The patients received and were discharged with a TPV were followed up annually according to a standardized protocol. During a median follow-up of 4.5 years (range, 0.4-7 years), 32 patients underwent right ventricular outflow tract reintervention for obstruction (n=27, with stent fracture in 22), endocarditis (n=3, 2 with stenosis and 1 with pulmonary regurgitation), or right ventricular dysfunction (n=2). Eleven patients had the TPV explanted as an initial or second reintervention. Five-year freedom from reintervention and explantation was 76±4% and 92±3%, respectively. A conduit prestent and lower discharge right ventricular outflow tract gradient were associated with longer freedom from reintervention. In the 113 patients who were alive and reintervention free, the follow-up gradient (median, 4.5 years after implantation) was unchanged from early post-TPV replacement, and all but one patient had mild or less pulmonary regurgitation. Almost all patients were in New York Heart Association class I or II. More severely impaired baseline spirometry was associated with a lower likelihood of improvement in exercise function after TPV replacement. The authors reported that TPV replacement with the Melody valve provided good hemodynamic and clinical outcomes up to seven years after implantation. Primary valve failure was rare. The main cause of TPV dysfunction was stenosis related to stent fracture, which was uncommon once prestenting became more widely adopted.
One of the clinical and regulatory concerns with the Melody valve has been fracture of the balloon-expandable stent in which the bovine jugular venous valve is housed. In early reports from Europe, survival free from Melody valve stent fracture (MSF) was 85% at one year and 75% at two years after implant. A similar trend was observed in preliminary analyses of the U.S. Melody Valve IDE cohort. McElhinney et al. (2011) assessed risk factors for Melody stent fracture (MSF), valve dysfunction, and reintervention after TPV placement in the complete IDE cohort after all patients had reached the one year follow-up interval (n=150). Existing conduit stents from a prior catheterization were present in 37 patients (25%, fractured in 12); one or more new prestents were placed at the TPV implant catheterization in 51 patients. During follow-up (median, 30 months), MSF was diagnosed in 39 patients. Freedom from a diagnosis of MSF was 77±4% at 14 months (after the one year evaluation window) and 69±9% at 39 months (three-year window). On multivariable analysis, implant within an existing stent, new prestent, or bioprosthetic valve (combined variable) was associated with longer freedom from MSF (p<0.0001), whereas TPV compression (p=0.01) and apposition to the anterior chest wall (p=0.02) were associated with shorter freedom from MSF. Freedom from RVOT reintervention was 86±4% at 27 months. Among patients with a MSF, freedom from RVOT reintervention after MSF diagnosis was 49±10% at 2 years. Factors associated with reintervention were similar to those for MSF. The authors reported that MSF was common after TPV implant and was more likely in patients with severely obstructed RVOT conduits and when the TPV was directly behind the anterior chest wall and/or clearly compressed. A TPV implant site protected by a prestent or bioprosthetic valve was associated with lower risk of MSF and reintervention.

McElhinney et al. (2010) evaluated short and medium-term outcomes in the expanded Melody U.S. Trial (n=136). Implantation was attempted in 124 patients, and was achieved successfully in all except one. Placement was not attempted in the other 12 patients due to the risk of coronary artery compression (n=6) or other clinical or protocol contraindications. There was one death from intracranial hemorrhage after coronary artery dissection, and one valve was explanted after conduit rupture. The median peak RVOT gradient was 37 mm Hg prior to implantation and 12 mm Hg immediately following implantation. Pulmonary regurgitation (PR) was moderate or severe in 92 patients prior to implantation, and no patient had greater than mild PR immediately after implantation or during follow-up (≥ one year in 65 patients). Freedom from stent fracture was 77.8% ± 4.3% at 14 months, and freedom from Melody valve dysfunction or reintervention was 93.5 ± 2.4% at one year. A higher RVOT gradient at discharge and younger age were associated with shorter freedom from dysfunction.

The Melody U.S. Clinical Trial (n=34) was designed to evaluate the safety, procedural success, and short-term effectiveness of the Melody transcatheter pulmonary valve in patients with dysfunctional right ventricular outflow tract conduits. Early results were published by Zahn et al. (2009). Patients underwent catheterization for intended Melody valve implantation at three centers between January and September, 2007. The mean age was 19.4 ± 7.7 years. Doppler mean gradient was 28.8 ± 10.1 mm Hg, and 94% of patients had moderate or severe pulmonary regurgitation (PR). Implantation was successful in 29 of 30 attempts, and not attempted in four patients. Complications included one conduit rupture requiring urgent surgery and device removal, one distal pulmonary artery guidewire perforation, and one instance of wide complex tachycardia. Peak systolic conduit gradient fell from 37.2 ± 16.3 mm Hg to 17.3 ± 7.3 mm Hg. None of the patients had more than mild PR. At 6-months, conduit Doppler mean gradient was 22.4 ± 8.1 mm Hg, and pulmonary regurgitation fraction as measured by magnetic resonance imaging was significantly improved (3.3 ± 3.6% vs. 27.6 ± 13.3%, p<0.0001). Stent fracture occurred in 8 of 29 implants. Three of these patients were subsequently treated with a second Melody valve for recurrent stenosis during follow-up. The authors concluded that implantation of the Melody valve for RVOT conduit dysfunction can be performed by experiences operators and appears safe, and has encouraging acute and short-term outcomes. Longer follow-up and a larger patient experience are needed to determine the ultimate role of this therapy in the treatment of conduit dysfunction.

Melody U.S. Post Approval Study: In a multicenter prospective nonrandomized study, Armstrong et al. (2014) evaluated the short-term effectiveness of the Melody TPV. This study sought to confirm if the short-term hemodynamic effectiveness of the Melody TPV achieved by real-world providers is equivalent to the historical results established in the initial five-center Investigational Device Exemption trial. Patients with dysfunctional RVOT conduits were entered in this study at 10 centers. The primary endpoint was acceptable hemodynamic function at six months post-implantation, defined as a composite of RVOT echocardiographic mean gradient ≤30 mm Hg, pulmonary regurgitation less than moderate as measured by echocardiography, and freedom from conduit reintervention and reoperation. Cardiac catheterization was performed in 120 patients for potential implantation of the Melody TPV; of these, 100 patients were implanted, with a 98.0% procedural success rate.
There were no procedure-related deaths. Acceptable hemodynamic function at six months was achieved in 96.7% of patients with evaluable data (87.9% of the entire implanted cohort), with results maintained through one year. No patient had moderate or severe pulmonary regurgitation after implantation. No patient required catheter reintervention in the first year after implantation, and two patients required reoperation for conduit replacement. The rate of freedom from TPV dysfunction was 96.9% at 1 year.

**SAPIEN COMPASSION Study:** The ongoing COMPASSION study (Clinicaltrials.gov number NCT00676689) was considered in the PMA approval process (FDA, 2016). Per the FDA Summary of Effectiveness and Safety Data (SSED), this prospective, non-randomized, seven center study (n=69) assessed the safety and effectiveness of pulmonic implantation of the SAPIEN THV. The SAPIEN THV is the first generation valve of the SAPIEN device line and is no longer available for distribution. Patient inclusion criteria: weight ≥ 35 kilograms; in situ conduit size of 20-26 mm in diameter; moderate or severe pulmonary regurgitation defined as ≥ 3+ pulmonary regurgitation (PR) by transthoracic echocardiogram (TTE) or RVOT conduit obstruction with a mean gradient of ≥ 35 mmHg by TTE; symptomatic as evidenced by cardiopulmonary exercise testing; catheterization was determined to be feasible by the treating physician. All patients were scheduled to return for follow-up examinations at day 1 post-procedure, discharge, 30 days, six months, 12 months, and annually thereafter for five years postoperatively. Primary outcome measure was freedom from device- or procedure-related death and/or reintervention at one year. The secondary endpoints included:

1) Freedom from Major Adverse Cardiac and Cerebrovascular Events (MACCE) at six months. MACCE was defined as all-cause mortality, myocardial infarction, reintervention, vascular injury resulting in the need for an unplanned vascular intervention, stroke and pulmonary embolism.

2) Functional improvement at six months as defined by:
   a. Improved valve hemodynamics as demonstrated via TTE:
      i. Decrease in pulmonary regurgitation to mild or less for regurgitant lesions
      ii. Decrease in mean pulmonary gradient to less than 30mmHg for stenotic lesions
      iii. Improvement in both i) and ii) above for mixed lesions
   b. Improvement of ≥ 1 NYHA functional class from baseline for patients with NYHA functional class ≥ 2 at baseline.
   c. Freedom from recurrent pulmonary stenosis.

   Freedom from device- or procedure-related death and/or reintervention at one year met the pre-specified performance goal of 75%. At five years, the freedom from device- or procedure-related death and/or reintervention was 77.1%. There were no device- or procedure-related patient deaths at five years. Freedom from surgical pulmonic valve repair was 98.3% at one year and 91.8% at five years. Freedom from transcatheter pulmonic valve implantation was 97.1% at one year and 85.8% at five years. Freedom from balloon valvuloplasty was 100% at one year and 93.7% at five years. Freedom from other types of reintervention was 100% at one year and 97.9% at five years. Two patients experienced a device migration (2/79, 2.5%) early in the study. The instructions for use were modified; no other device migrations occurred in the study after this modification. Serious Adverse Events (SAE) for RVOT conduit ruptures occurred in 5/79 (6.3%) patients. These five ruptures were related to balloon valvuloplasty or placement of a pre-stent and no ruptures occurred during placement of the SAPIEN THV. Functional improvement at 6 months reported a decrease in pulmonary regurgitation to mild or less in 96.2% of patients; improved pulmonary stenosis mean gradient was 93.8%; functional improvement in NYHA was 92.2%; and freedom from recurrent pulmonary stenosis was 100%. Improvement in conduit mean gradient decreased from 21.1±14.3 mmHg at baseline to 10.1±7.2 mmHg at 30 days 10.0 ± 7.3 mmHg at one year and 12.8±7.8 mmHg at five years. An improvement in conduit peak gradient was demonstrated, as it decreased from 37.2±25.5 mmHg at baseline to 18.7±15.0 mmHg at 30 days, 17.4 ± 12.1 mmHg at one year and 21.6±14.5 mmHg at five years. Moderate/severe pulmonic regurgitation decreased from 90% at baseline to 2% at 30 days, 4 % at one year and 0% at five years. There was a trend showing patient functional improvement over time, as 22% of the patients were in NYHA class 1 at baseline, 84% at one year and 94% at five years.

Chowdhury et al. (2013) conducted a prospective, multicenter study (COMPASSION study) to evaluate echocardiographic changes at one and six months after SAPIEN valve implantation in the pulmonary position (n=33). Pulmonary valve function and the right ventricle after SAPIEN TPV placement were evaluated. Inclusion criteria: weight ≥35 kg; conduit size ≥16 mm and ≤24 mm; moderate or severe PR; symptoms as evidenced by cardiopulmonary exercise testing. PPVI significantly improved peak and mean conduit stenosis gradient; RV end-diastolic area; RV endsystolic area; indexed RV end-diastolic area; tricuspid regurgitation (TR) peak gradient; indexed TR jet area (p<0.01 for all measures). The benefit was maintained for six months. Proportion of
patients with grade ≥2 PR was reduced from 94% at baseline to 12% at six mos (p<0.01). Complications were not reported. Limitations of this study include small sample size and short-term follow-up.

Kenny et al. (2011) conducted a phase 1 U.S. Food and Drug Administration–approved clinical trial (COMPASSION study) to evaluate the safety and effectiveness of the Edwards SAPIEN transcatheter heart valve (THV) in the pulmonary position in patients with moderate to severe pulmonary regurgitation with or without stenosis. This prospective, multicenter uncontrolled study included 36 patients from four centers (three in the United States and one in Europe). Follow-up was six months. The study included patients with dysfunctional right ventricle (RV)-pulmonary artery (PA) conduit; body weight ≥35 kg; in situ conduit diameter ≥16 mm and ≤24 mm. Patients had varied clinical histories. Primary and secondary outcome measures are outlined in the above study. Device success was achieved in 31 of 36 patients (86.1%). Hemodynamic measures, conduit peak and mean gradient, estimated RV pressure, pulmonary regurgitant fraction (%), RV end diastolic volume (mL/m2), pulmonary regurgitation severity, cardiopulmonary exercise testing, NYHA functional class improved from baseline to six months. Freedom from reintervention was 97% with one patient undergoing elective placement of a second valve due to conduit-induced distortion of the initial implant. Complications included PPV migration (9.1%); pulmonary hemorrhage (6.1%); ventricular fibrillation (3%); stent embolization to RV (3%). This study was limited by small sample size and lack of long-term follow-up.

Additional Studies: Butera et al. (2013) conducted a prospective, multicenter web-based registry study of percutaneous pulmonary valve implantation (PPVI) with the Melody valve. The registry was of the Italian Society of Pediatric Cardiology. Between October 2007 and October 2010, 63 patients were included in the registry (median age: 24 years; range 11-65 years). Results suggest that PPVI has good procedural and mid-term success and might delay surgical intervention in more than 80% of patients. However, serious complications can occur and valve failure occurred in almost 20% of patients during follow-up. The authors concluded that longer follow-up and larger series are needed.

Vezmar et al. (2010) conducted a case series to evaluate the physiological and clinical consequences of percutaneous pulmonary valve implantation (PPVI) in patients with chronic right ventricular outflow tract (RVOT) obstruction and volume overload (n=28). Of 28 patients, 16 had the Melody valve implanted within a bioprosthetic valve. The procedure resulted in acute improvement in symptoms, hemodynamic status and objective findings of exercise performance. There were no acute device-related complications, with stent fractures were noted in 10.8% of patients. Early follow-up demonstrated persistent improvement in ventricular parameters, PR, and objective exercise capacity.

Eiken et al. (2011) published results of 102 consecutive percutaneous pulmonary valve implantations, using the Melody valve, performed at two centers in Germany between 2006 and 2010. The median patient age was 21.5 years. Sixty-one patients had undergone surgical correction of a Tetralogy of Fallot/pulmonary atresia with ventricular septal defect, and 14 had a common arterial trunk; the remaining patients had been treated surgically for transposition of the great arteries (n=9) or aortic stenosis (n=8), or had a variety of other cardiac lesions (n=10). The majority of conduits (79) used during previous surgery were homografts. The median peak systolic RVOT gradient between the right ventricle and the pulmonary artery decreased immediately following the procedure from 37 mmHg (29–46 mmHg) to 14 mmHg (9–17 mmHg, p< 0.001). Pulmonary regurgitation assessed by MRI was reduced from a median of 16% (5–26%) to 1% (0–2%, p<0.001). The median end-diastolic RV-volume index also decreased significantly (p=0.001). One patient died due to compression of the left coronary artery. At a median follow-up of 357 days (99–388 days), the mean doppler gradient in the RVOT decreased from a pre-procedure median of 36 mmHg (26–44) to a median of 15 mmHg (12–20) at the latest follow-up (p<0.0001). The authors concluded that PPVI can be performed by an experienced structural heart disease interventionalist in patients with RVOT dysfunction. Medium and long term follow up needs to be assessed to document sustained benefit, however. It remains to be proved whether the improvements in hemodynamics persist, and the goal to reduce the number of cardiothoracic operations during the lifetime of the patient can be achieved.

Non-FDA-approved uses of Transcatheter Pulmonary Valve (TPV) Implantation:
There are potential off-label uses of TPV implantation that have been reported in the literature such as use in native and postsurgical, nonconduit RVOT. These include use of FDA-approved devices for non-FDA-approved indications and use of devices that are not FDA-approved. Generally these studies are small non-comparative
studies lacking long-term follow-up. Ruiz et al. (2019) address the issues that need to be resolved for the use of TPV implantation in nRVOT include establishing appropriate pre-procedural imaging criteria for patient and valve selection to perform TPV implantation in nRVOT; evaluation of feasibility and safety of larger transcatheter valves in nRVOT; assessment of long-term outcomes and durability with transcatheter valves in nRVOT and regulatory approval of TVP implantation in nRVOT.

Devices that are being investigated include The Harmony™ TPV (Medtronic) which is a self-expandable device designed to accommodate the larger RVOTs typical in patients with native RVOTs meaning those who have had previous surgery and are left with a large, compliant, irregular RVOT. The Harmony TPV, currently available in one size, is being evaluated in the Study of the Native Outflow Tract Transcatheter Pulmonary Valve (NCT01762124), a FDA–approved feasibility study. Another investigational system is The Alterra Adaptive Prestent™ (Edwards Life Sciences, Irvine, CA) which is a size reducer and docking station for the 29-mm SAPIEN S3 valve in the RVOT (Balzer, 2019; Ruiz, et al., 2019; Cabalka, et al., 2018; Martin, et al., 2018; Zahn, et al., 2018; Bergersen, et al., 2017; Cools, et al., 2015; Malekzadeh-Milani, et al., 2014; Meadows, et al., 2014; Demkow, et al., 2014; Boshoff, et al., 2013; Odemis, et al., 2013).

Professional Societies/Organizations

The ACC/AHA 2008 Guidelines for the Management of Adults with Congenital Heart Disease does not include recommendations for transcatheter pulmonary valve implantation (Warnes, et al., 2008). This guideline was updated in 2018 (Stout, et al., 2018). The updated guideline addresses percutaneous pulmonary replacement with recommendations for Tetralogy of Fallot (TOF) stating:

- Pulmonary valve replacement (surgical or percutaneous) for relief of symptoms is recommended for patients with repaired TOF and moderate or greater pulmonary regurgitation (PR) with cardiovascular symptoms not otherwise explained (Class or Recommendation I; Level of evidence B-NR)
- Pulmonary valve replacement (surgical or percutaneous) is reasonable for preservation of ventricular size and function in asymptomatic patients with repaired TOF and ventricular enlargement or dysfunction and moderate or greater PR (Class or Recommendation IIa; Level of evidence B-NR)

Hayes Medical Technology Report
An updated 2016 Hayes, Inc. Medical Technology Directory Report, Percutaneous Pulmonary Valve Implantation for Right Ventricular Outflow Tract Defects, reports that two percutaneous pulmonary valve implantation (PPVI) systems are available: the Medtronic Melody pulmonary valve and the Edwards SAPIEN valve The Melody valve is the most researched percutaneous pulmonary valve system. The Edwards SAPIEN valve is used less frequently as a percutaneous pulmonary valve. The Hayes Directory Report states that the body of evidence is large in size and of low quality, consisting of observational studies. The available observational studies found generally consistent short-term benefits of PPVI for RVOT, with some results dependent on etiology and pathology of the pulmonary valve defect, operator experience, and procedure protocol. Most of the hemodynamic measures improved consistently across 22 observational studies (n=31-155). Only six observational studies (n=33-155) evaluated pulmonary regurgitation, but they reported significant improvement from baseline; 60%-100% of patients had no or only mild disease following PPVI; however, long-term pulmonary regurgitation severity remains unknown. Results from 11 observational studies were less consistent, with some showing significant improvements from baseline and others showing small improvements only. The PPVI procedure itself was technically successful in most cases, six studies reported procedure success rates ranging from 82.5%-100%; but reintervention was required in approximately 25%-33% of patients at five-year follow-up. Overall, PPVI was relatively safe, compared with open chest surgery; however, it has caused severe, potentially life-threatening complications, including stent fracture (0-32%); compression or injury of the left coronary artery during the procedure (0.7-0.98%); endocarditis (0-10%), which may lead to blood stream infections (9.5%). Seven deaths were definitively or possibly related to PPVI. There is a learning curve associated with PPVI, and experience with this technique improves outcomes and reduces the risk for complications (Hayes, 2013b; updated 2016; 2017; 2018).
Summary–Transcatheter Pulmonary Valve Implantation: Transcatheter pulmonary valve implantation has been explored as an alternative to conventional valve surgery for the treatment of pulmonary regurgitation and right ventricular outflow tract (RVOT) dysfunction. These conditions often occur in patients with previously repaired pulmonary valves. Pulmonary valve surgery requires cardiopulmonary bypass, and involves insertion of a pulmonary conduit, with or without a valve, to re-establish blood flow to the pulmonary artery. Conduits require frequent replacement due to patient growth and conduit degeneration. Although the published evidence is limited, transcatheter pulmonary valve implantation appears to be a reasonable alternative in carefully selected patients. This procedure may provide improved hemodynamic function and extend the longevity of the existing conduit, and may defer the need for conduit replacement, resulting in a reduction in the number of open heart surgeries required over a lifetime.

Mitral Valve

Mitral regurgitation (MR) is a diverse disease that results from dysfunction of any of the portions of the complex mitral valve apparatus, including the chords, leaflets, annulus, and left ventricle. The mitral valve allows blood to flow from the left atrium to the left ventricle. Mitral valve regurgitation (MR) happens when the valve doesn't close properly, allowing blood to flow back into the atrium from the ventricle during systole. The heart has to work harder, resulting in an enlarged left ventricle. If not treated, this can lead to problems including heart failure.

MR is classified on the basis of two broad categories of dysfunction, namely primary (organic or degenerative) disease, which primarily affects the leaflets (e.g., fibromuscular dysplasia, mitral valve prolapse, rheumatic disease), and secondary (ischemic or functional) diseases, which spare the leaflets (e.g., diseases of the atrium and ventricle, including ischemic dysfunction and dilated cardiomyopathy). There are instances in which both primary and secondary MR are present. Identification of the cause and type (primary or secondary) of MR is required for appropriate management of MR and associated conditions (Herrmann, et al., 2019, Gaasch, 2019; Nishimura, et al., 2017).

There is a limited role for medical management in patients with chronic primary MR, since mitral valve intervention is required to address the primary process. Surgical treatment is considered for patients with functional disability and for patients with no symptoms or only mild symptoms but with progressively deteriorating left ventricle (LV) function or progressively increasing LV dimensions, as documented by noninvasive studies. Without surgical treatment, the prognosis for patients with MR and heart failure is poor, so mitral valve repair or replacement is recommended for symptomatic patients (Thomas, et al., 2019; Gaasch, 2019).

The best therapy for chronic secondary MR is not clear because MR is only one component of the disease, with clinical outcomes also related to severe LV systolic dysfunction, coronary disease, idiopathic myocardial disease, or other diseases affecting the heart muscle. Thus, restoration of mitral valve competence is not curative. First-line therapy for secondary MR is management of heart failure with reduced ejection fraction including pharmacologic therapy as well as cardiac resynchronization therapy, as indicated. Treatment of secondary MR includes assessment and management of concurrent conditions, particularly coronary artery disease (CAD). Standard recommendations for coronary revascularization apply. This includes surgical revascularization for patients with ischemic cardiomyopathy (LVEF ≤35%) with CAD amenable to revascularization. Mitral valve intervention (transcatheter mitral valve repair or mitral valve surgery) is proposed in selected patients with secondary MR with criteria including the severity of MR, symptoms on optimal medical therapy, and presence of a concurrent indication for cardiac surgery (coronary artery bypass graft surgery [CABG] or aortic valve surgery) (Gaasch, 2019; Nishimura, et al., 2017).

Many patients who have mitral valve regurgitation are poor candidates for open surgery, cardiopulmonary bypass, and cardiac arrest, due to comorbidities, frailty, or scarring from prior surgeries. People with degenerative or functional MR are usually older (typically over 70 years) and frail, with multiple comorbidities. This increases the perioperative risks of morbidity and mortality for open heart surgery. Percutaneous MV repair may improve the health of these patients without exposing them to the risks of open surgery (NICE, 2019; Hayes, 2018).

Percutaneous/Transcatheter Mitral Valve Repair (PMVR): Many different devices have been created for PMVR which are in various stages of development (e.g., NeoChord DS1000 System, NeoChord, Minneapolis, MN; Mitra-Spacer™, Cardiosolutions, West Bridgewater, Mass; MitraFlex, TransCardiac Therapeutics, Atlanta,
Ga (Krishnaswamy, et al. 2020; Herrmann, et al., 2019). The only devices that have been evaluated in at least one clinical trial are the Carillon Mitral Contour System (Cardiac Dimensions, Inc., Kirkland, WA), which is an investigational device in the U.S., and the FDA-approved MitraClip Mitral Valve Repair System (Herrmann, et al., 2019; Hayes, 2018; Armstrong, et al., 2019).

Investigational transcatheter-based approaches for mitral valve repair/replacement include indirect annuloplasty, direct or left ventricular annuloplasty, hybrid surgical, chordal replacement, and left ventricular remodeling (Armstrong, et al., 2019; Herrmann, 2019).

The MitraClip system consists of implant catheters and the MitraClip device, a permanent implant that attaches to the mitral valve leaflets. The procedure results in a double opening of the mitral valve that allows greater closure and reduces mitral regurgitation. The MitraClip has been used to treat both primary and secondary MR. A multidisciplinary dedicated heart team approach (including primary [general] cardiologists, interventional cardiologists, cardiac surgeons, imaging specialists, valve and heart failure specialists, and cardiac anesthesiologists) is recommended for the evaluation and care of potential candidates for transcatheter mitral valve repair (Armstrong, et al., 2019).

Transcatheter MVR with the MitraClip device is performed in the cardiac catheterization laboratory using a combination of fluoroscopic and transesophageal echocardiographic (TEE) guidance. The procedure is usually performed under general anesthesia. Antithrombotic therapy is recommended at the time of and following the procedure. Access is obtained via the femoral vein, and a transseptal puncture is performed to cross the interatrial septum into the left atrium. The MitraClip steerable catheter is then advanced into the left atrium, and echocardiographic guidance is utilized to align the MitraClip device with the regurgitant valve leaflets and into the left ventricle. The MitraClip is then drawn back with the clip arms open in order to grasp the leaflets at the site of regurgitation. The arms are then closed, and Doppler echocardiography is used to determine the reduction in MR. If the reduction in MR is not adequate, the clip arms can be reopened and the placement adjusted prior to final device deployment. It has been reported that in approximately 40 percent of cases, an additional MitraClip may be implanted in order to adequately reduce MR. Real-time two- and three-dimensional transesophageal echocardiography guides the positioning of the trans-septal puncture during the procedure, placement of the mitral clip, and assessment of the mitral valve morphology and regurgitation severity following the clip placement (Armstrong, et al., 2019).

Transcatheter MVR is associated with an overall complication rate of 15-19% at 30 days. Early (30-day) complication rates are primarily due to need for periprocedural blood transfusion, while late events are primarily related to underlying heart failure or patient comorbidities. Complications include access site bleeding, partial clip detachment, and rarely device embolization or development of mitral stenosis (Armstrong, et al., 2019).

**U.S. FDA–MitraClip NT Clip Delivery System (CDS) and MitraClip NTR/XTR CDS (Abbott Vascular, Menlo Park, CA):** The MitraClip CDS received FDA approval through the PMA process on October 24, 2013 (P100009). It is indicated for the percutaneous reduction of significant symptomatic mitral regurgitation (MR ≥ 3+) due to primary abnormality of the mitral apparatus (degenerative MR) in patients who have been determined to be at prohibitive risk for mitral valve surgery by a heart team, which includes a cardiac surgeon experienced in mitral valve surgery, and in whom existing comorbidities would not preclude the expected benefit from reduction of the MR. The device is contraindicated in patients who cannot tolerate procedural anticoagulation or post procedural antiplatelet regimen, and those with active endocarditis of the mitral valve, rheumatic mitral valve disease, or evidence of intracardiac, inferior vena cava or femoral venous thrombus (FDA, 2013).

The MitraClip CDS has since been phased out and is no longer in commercial distribution. The MitraClip NT CDS and MitraClip NTR/XTR CDS are design iterations of the MitraClip CDS. The former was approved under P100009/S015 on May 10, 2016; the latter was approved under P100009/S025 on May 23, 2018 (FDA, 2019).

On March 14, 2019 the MitraClip NT CDS and MitraClip NTR/XTR CDS received supplemental FDA PMA approval (P100009/S028) expanding the indication to include secondary MR. The devices, when used with maximally tolerated guideline-directed medical therapy (GDMT), are indicated for the treatment of symptomatic, moderate-to-severe or severe secondary (or functional) mitral regurgitation (MR; MR ≥ Grade III per American
Society of Echocardiography criteria) in patients with a left ventricular ejection fraction (LVEF) $\geq 20\%$ and $\leq 50\%$, and a left ventricular end systolic dimension (LVESD) $\leq 70\ mm$ whose symptoms and MR severity persist despite maximally tolerated GDMT as determined by a multidisciplinary heart team experienced in the evaluation and treatment of heart failure and mitral valve disease (FDA, 2019).

The MitraClip NT CDS and MitraClip NTR/XTR CDS are contraindicated in patients with the following conditions:
- patients who cannot tolerate procedural anticoagulation or post procedural anti-platelet regimen
- active endocarditis of the mitral valve
- rheumatic mitral valve disease
- evidence of intracardiac, inferior vena cava (IVC) or femoral venous thrombus

Data from the Cardiovascular Outcomes Assessment of the MitraClip Percutaneous Therapy for Heart Failure Patients with Functional Mitral Regurgitation (COAPT) Trial (Stone, et al., 2018) was the basis for the PMA approval decision (NCT01626079).

**Literature Review: Percutaneous Mitral Valve Repair**

**COAPT (Cardiovascular Outcomes Assessment of the MitraClip Percutaneous Therapy for Heart Failure Patients with Functional Mitral Regurgitation) Trial:** Stone et al. (2018) reported if patients with heart failure who have secondary mitral regurgitation (MR) due to left ventricular dysfunction have improved health outcomes with transcatheter mitral-valve repair. Patients were randomized to transcatheter mitral valve repair plus medical therapy (n=302) or medical therapy alone (n=312). Eligible patients included those with ischemic or nonischemic cardiomyopathy with a left ventricular ejection fraction of 20-50%; moderate to severe (grade 3+) or severe (grade 4+) secondary MR confirmed by echocardiography before enrolment; symptomatic (New York Heart Association [NYHA] functional class II, III, or IVa [ambulatory]) despite using stable maximal doses of guideline-directed medical therapy and cardiac resynchronization therapy (if appropriate), which were administered in accordance with guidelines of professional societies; mitral valve surgery was deemed not to be appropriate.

Each patient was assessed by a team that consisted of a heart-failure specialist, an interventional cardiologist, and a cardiothoracic surgeon with expertise in mitral valve disease. The primary effectiveness endpoint was all hospitalizations for heart failure within 24 months of follow-up, including recurrent events in patients with more than 1 event. The primary safety endpoint was freedom from device-related complications at 12 months (a prespecified objective performance goal was set at 88%). Median follow-up in device group was 22.7 months (16.5 months in control group). Hospitalizations for heart failure within 24 months was 35.8% per patient-year in the device group as compared with 67.9% per patient-year in the control group (p<0.001). Rate of freedom from device-related complications at 12 months was 96.6% (p<0.001) for comparison with the performance goal.

Death from any cause within 24 months occurred in 29.1% of the patients in the device group as compared with 46.1% in the control group (p=0.001). The authors concluded that "among patients with heart failure and moderate-to-severe or severe secondary MR who remained symptomatic despite the use of maximal doses of guideline-directed medical therapy, transcatheter mitral-valve repair resulted in a lower rate of hospitalization for heart failure and lower all-cause mortality within 24 months of follow-up than medical therapy alone. The rate of freedom from device-related complications exceeded a prespecified safety threshold". A reported limitation of the study states that long term follow-up, which is to be ongoing thru five years, is necessary to characterize the safety and effectiveness of the device.

Arnold et al. (2019) reported the health status outcomes of patients in the COAPT study. Health status was assessed at baseline and at one, six, 12, and 24 months with the Kansas City Cardiomyopathy Questionnaire (KCCQ) and the SF-36 health status survey. The primary health status endpoint was the KCCQ overall summary score (KCCQ-OS; range 0 to 100; higher=better; minimum clinically important difference=5 points). At baseline, patients had substantially impaired health status. While health status was unchanged over time in the standard care arm, patients randomized to transcatheter mitral-valve repair (TMVR) demonstrated substantial improvement in the KCCQ-OS at one month, with only slight attenuation of this benefit through 24 months. At 24 months, 36.4% of TMVR patients were alive with a moderately large (≥10-point) improvement versus 16.6% of standard care patients (p< 0.001). TMVR patients also reported better generic health status at each time point. The authors reported the following study limitations: COAPT was a nonblinded trial which may introduce bias; the true health status of patients who died, had they survived, is not knowable; the durability of the health status benefit of TMVR beyond 24 months is not known, which is an important consideration in patients with underlying cardiomyopathy and comorbidities.
Multicenter Study of Percutaneous Mitral Valve Repair MitraClip Device in Patients with Severe Secondary Mitral Regurgitation (MITRA-FR) (NCT01920698): Obadia et al. (2018) reported if percutaneous mitral-valve repair (PMVR) improves clinical outcomes in patients who have chronic heart failure with reduced left ventricular ejection fraction and severe secondary mitral-valve regurgitation. Patients were randomized in a 1:1 ratio to undergo PMVR in addition to receiving medical therapy (intervention group; n=152) or to receive medical therapy alone (control group; n=152). Patients were eligible if they had severe secondary MR with a regurgitant volume of >30 ml per beat or an effective regurgitant orifice area of >2.0 mm² as assessed by echocardiography, in accordance with the 2012 guidelines of the European Society of Cardiology and the European Association for Cardio-Thoracic Surgery. Patients were also required to have a LVEF between 15% and 40% and to have chronic heart failure symptoms (assessed as NYHA functional class ≥II). Patients were considered to be unsuitable candidates for mitral valve surgery, with a EuroSCORE II value of 6.6 (IQR 3.5 to 11.9) in the PMVR group compared with 5.9 (IQR 3.4 to 10.4) in the control group. Primary outcome measure was composite of death and readmission for heart failure. Secondary outcome measures were echocardiographic parameters, MR grade, NYHA class and quality of life. At 12 months, the rate of the primary outcome was 54.6% (83 of 152 patients) in the intervention group and 51.3% (78 of 152 patients) in the control group (p=0.53). The rate of death from any cause was 24.3% (37 of 152 patients) in the intervention group and 22.4% (34 of 152 patients) in the control group. The rate of unplanned hospitalization for heart failure was 48.7% (74 of 152 patients) in the intervention group and 47.4% (72 of 152 patients) in the control group. Reported limitation is missing follow-up data for the assessment of echocardiography, functional status, natriuretic peptide, and quality of life. At one year at least 48 patients in the intervention group had MR grade of 2+ or higher. The authors concluded that “among patients with severe secondary MR, the rate of death or unplanned hospitalization for heart failure at one year did not differ significantly between patients who underwent percutaneous mitral-valve repair in addition to receiving medical therapy and those who received medical therapy alone”.

EVEREST II (Endovascular Valve Edge-to-Edge Repair Study): EVEREST II is a two-part multicenter, randomized controlled trial to evaluate the safety and efficacy of endovascular mitral valve repair using the MitraClip device compared with conventional mitral valve surgery in patients with moderate to severe mitral regurgitation. EVEREST II consists of a prospective randomized arm and a high-risk registry arm (Clinicaltrials.gov number NCT00209274).

EVEREST II Randomized Arm
Feldman et al. (2015; 2011) reported one and five-year results of the EVEREST II study. Patients were randomized to percutaneous mitral valve repair (PMVR) with the MitraClip device (n=184) or conventional mitral valve surgery (n=95) in a 2:1 ratio. Blinding of patients and treating personnel was not possible. A total of 21/279 patients who underwent randomization withdrew consent for treatment (3% in the PMVR group and 16% in the surgery group). Eligible patients had moderate-to-severe (3+) or (4+) chronic MR and were either symptomatic with left ventricular ejection fraction (LVEF) >25% and LV end-systolic diameter ≤ 55 mm or asymptomatic with one or more of the following: LVEF 25% to 60%, LV end-systolic diameter ≥ 40 mm, new-onset atrial fibrillation, or pulmonary hypertension (pulmonary artery systolic pressure >50 mm Hg at rest or >60 mm Hg with exercise). Patients with both functional and degenerative MR were included. The study compared treatment groups using the following endpoints through 5 years within the all-treated cohort: 1) freedom from death, surgery for MV dysfunction, and 3+ and 4+ MR; 2) freedom from death; 3) freedom from surgery for MV dysfunction; and 4) freedom from death and surgery for MV dysfunction. Of 258 treated patients, 243 (94%) complied with the protocol for the 12-month follow-up. After one year, 37/178 (21%) patients allocated to PMVR went on to receive surgical intervention. The primary outcome at one year demonstrated that conventional surgery was more effective than PMVR for reducing MR. However, improvements in left ventricular (LV) remodeling and clinical outcomes were similar for both approaches and the percutaneous approach demonstrated a greater level of safety than did surgery.

The 5-year analysis of the all-treated cohort included 154 (87%) and 56 (70%) patients in the device and surgical arms, respectively. At 5 years, the rate of the composite endpoint of freedom from death, MV surgery, or reoperation, and 3+ or 4+ MR in the as-treated population was 44.2% versus 64.3% in the percutaneous repair and surgical groups, respectively (p=0.01). The difference was driven by increased rates of 3+ or 4+ MR (12.3% vs. 1.8%; p=0.02) and surgery (27.9% vs. 8.9%; p=0.003) with percutaneous repair. After percutaneous repair,
78% of surgeries occurred within the first 6 months. Beyond 6 months, rates of surgery and moderate-to-severe MR were comparable between groups. Five-year mortality/death rates were 20.8% and 26.8% (p=0.36) for percutaneous repair and surgery, respectively. Limitations included no blinding of assessment to treatment; some patients with MR grade <3 included in violation of inclusion criteria; 20% patients were excluded, withdrew, or were lost to follow-up. The authors concluded that although mitral valve repair surgery is superior to percutaneous mitral valve intervention using the MitraClip device in reducing the severity of MR, the device reduces symptoms, produces durable reduction of MR, and promotes favorable reverse remodeling of the left ventricle 5 years after intervention.

Four-year results of a randomized controlled trial of percutaneous repair versus surgery for mitral regurgitation (MR) were published by Mauri et al., for the EVEREST II Investigators (2013). Patients with grade 3+ or 4+ MR were randomized to percutaneous repair with the MitraClip device (n=184) or conventional mitral valve surgery (n=95) in a 2:1 ratio. The rate of the composite endpoint of freedom from death, surgery, or grade 3+ or 4+ MR at four years in the intention-to-treat population was 39.8% vs. 53.4% in the percutaneous repair group and surgical groups, respectively (p=0.070). Rates of death were 17.4% in the percutaneous repair group vs. 17.8% in the surgical group (p=0.914), and 3+ or 4+ MR was present in 21.7% in the percutaneous group vs. 24.7% in the surgical group (p=0.745). Surgery for mitral valve dysfunction was required in 29.4% in the percutaneous group vs. 2.2% in the surgical group at one year (p< 0.001) and 24.8% vs. 5.5% at four years (p< 0.001). The authors concluded that patients treated with percutaneous mitral valve repair more commonly required surgery to treat residual MR, although after the first year there were few surgeries required after either treatment, and there were no differences in the prevalence of moderate-severe and severe MR or mortality at four years.

**EVEREST II High Risk Registry Arm**

The EVEREST II High Risk Study, an arm of the EVEREST II study, was conducted to assess the safety and effectiveness of the MitraClip device in patients with significant MR at high risk of surgical mortality (Whitlow, et al., 2012). Outcomes of 78 patients with severe symptomatic functional or degenerative MR and an estimated surgical mortality rate of 12% or more were retrospectively compared to 36 patients who were screened but not enrolled. The comparator group received standard care over the twelve month period, with 86% managed medically and 14% undergoing mitral valve surgery. The major effectiveness endpoints for the study were freedom from death at 12 months, freedom from death and MR > 2+ at 12 months, and clinical measures of benefit at 12 months in surviving patients, defined as NYHA functional class, LV measurements, SF-36 Health Survey quality of life, and rehospitalizations for CHF. Protocol-predicted surgical mortality in the study group and comparator group was 18.2% and 17.4%, respectively. There were six procedure-related deaths, although there was no significant difference in 30-day mortality between the study group and comparator group (7.7% and 8.3%, respectively). The twelve-month survival rate was 76% in the study group and 55% in the comparator group (p=0.047). Of surviving patients in the study group with matched baseline and 12-month data, 78% had an MR grade of ≤ 2+; of these, a total of 33% had MR ≤ 1+ at 12 months. NYHA class and quality of life improved in the majority of patients. Reported limitation of this study included comparator group was recruited retrospectively, the patient number is limited, transesophageal echocardiograms were not available for review in all patients, and several of the patients included did not have appropriate anatomic criteria for MitraClip placement. 12-month echocardiographic and functional data were obtained and reported for surviving patients only, and no imputation for deceased patients’ data was performed. Thus, the matched data reported may represent an overestimation of the true benefit provided by MitraClip placement. The authors concluded that data from this study suggest a role for the MitraClip device in treating symptomatic patients with 3 to 4+ MR who are at high risk of mortality with MV surgery. MitraClip device placement in this high-risk group is feasible, effective in reducing symptoms and improving clinical status, and relatively safe in patients who otherwise have no safe option to reduce MR. Favorable LV remodeling demonstrates that the degree of reduction in MR obtained with the MitraClip device is hemodynamically important.

Kar et al. (2018) reported 5-year clinical outcomes to the EVEREST II High Risk Study. At five years, clinical follow-up was achieved in 90% of 78 enrolled patients (46 with functional MR (FMR) and 32 with degenerative MR (DMR)). The rate of post procedural adverse events declined from 30 days to one year follow-up and was stable thereafter through five years. Two patients (2.6%) developed mitral stenosis. Two patients underwent MV surgery, including one due to MS. A total of 42 deaths were reported through five years. Effectiveness measures at five years showed reductions in MR severity to ≤2+ in 75% of patients (p=0.0107), left ventricular (LV) end-
diastolic volume (−38.2 mL; 95% CI −55.0 to −21.4; p<0.0001) and LV end-systolic volume (−14.6 mL; 95% CI −27.7 to −1.5; p=0.0303) compared with baseline. The New York Heart Association (NYHA) functional class improved from baseline to five years (p<0.005), and septal-lateral annular dimensions remained stable with no indication of mitral annular dilation through five years. The authors concluded that long term safety and efficacy of MitraClip in high-surgical risk patients was maintained through five years. The observed mortality was most likely a consequence of the advanced age and comorbidity profile of the enrolled patients, while improvements in NYHA class in surviving patients were durable through long-term follow-up. The EVEREST II HRS is limited by the small study population, enrollment of both patients with functional MR and degenerative MR, and a lack of medical control group.

Additional Studies: In a prospective, multi-center study, Glower et al. (2014) evaluated the safety and effectiveness of the MitraClip in patients from both of the EVEREST II high-risk studies who had completed 12 months of follow-up. Of 351 patients enrolled in either the Everest HRR (n=78) or the REALISM HR study (n=273) a total of 327 of 351 patients completed 12 months of follow-up. Seventy percent of patients had functional mitral regurgitation (MR). The study included symptomatic patients with grades 3 to 4+ MR with valve morphology meeting the criteria necessary for MV device placement. All 351 patients met protocol entry criteria for high surgical risk: 151 patients (43.0%) had an STS score of at least 12%, and 200 patients (57.0%) had an STS score<12% but had at least 1 of the protocol-defined risk factors, which characterized the patient as high risk. Following MitraClip implantation at discharge 325 patients (86%) had MR reduced to less than or equal to 2+. At 12 months, 225 patients (84%) had MR less than or equal to 2+. While 16.4% of patients had MR >2+ at one year, the rate of surgery was low at 2.2%. Survival at 12 months was 77.2%. Patients had improvements in quality of life scores and NYHA functional class. Major adverse events at 30 days included death in 4.8%, myocardial infarction in 1.1%, and stroke in 2.6%. Author reported study limitations state that this data was collected in a narrowly defined group of patients based on specific surgical risk factors and specific anatomic suitability for the MitraClip device. Whether the results can be generalized to even higher-risk patients with life expectancies of <12 months is uncertain. There was no parallel surgical or medical control group in this study.

Maisano et al. (2013) published results from the ACCESS EU, a prospective multicenter nonrandomized post-approval study of MitraClip therapy in Europe. The primary objective of the first phase of the ACCESS-EU study (reported) was to gain information with regard to the use of the MitraClip system in Europe with respect to health economics and clinical care, to define demographic data of patients, and to provide further evidence of the safety and effectiveness of the MitraClip System in a real-world setting. A primary outcome was not specified. A total of 567 patients with severe MR were treated with MitraClip therapy at 14 European sites. Compared to patients in EVEREST II, patients in this study were older, presented with multiple comorbidities, and were determined to be at high surgical risk (similar to those enrolled in the EVEREST II high risk study, above). A total of 19 patients died within 30 days after the procedure. The Kaplan Meier survival at one year was 81.8%. There were no device embolizations. Thirty six patients (6.3%) required MV surgery within 12 months of the procedure. The severity of MR improved at twelve months compared to baseline (p<0.001), with 78.9% of patients free from MR severity > 2. At 12 months, 71.4% of patients were in NYHA Class I or II. The authors concluded that in the real-world, post-approval experience in Europe, patients undergoing the MitraClip therapy are high-risk, elderly patients, mainly affected by functional MR. In this patient population, the MitraClip procedure is effective with low rates of hospital mortality and adverse events.

Systematic Review and Meta-Analysis: In a meta-analysis, Marmagkiolis et al. (2019) evaluated the safety and efficacy of percutaneous mitral valve repair using the MitraClip device against conservative therapy for the management of functional mitral insufficiency. Studies comparing percutaneous mitral valve repair using the MitraClip device against conservative therapy for the management of functional mitral regurgitation were included. Seven studies with 1174 patients in the MitraClip group and 1015 patients in the medical therapy group met inclusion criteria. Two studies (COAPT and MITRA-FR) were RCTs, two were single-center observational studies, and three compared their MitraClip cohort with a propensity-matched patient group. Three studies were performed in North America and the rest were performed in Europe. Outside the United States, the device is more often used to treat functional mitral regurgitation in patients with heart failure. The 12-month mortality in the MitraClip group was 18.4% compared with 25.9% in the medical therapy group (p <0.002). The rate of readmission at 12 months was 29.9% in the MitraClip group compared with 54.1% in the medical therapy group (p <0.0001). The prognostic efficacy of MitraClip repair appears to be more substantial over longer follow-up period over medical therapy alone. The authors concluded that based on the results of this meta-analysis, percutaneous mitral valve repair with MitraClip appears to be
superior to medical therapy for symptomatic moderate-to-severe functional mitral insufficiency. Further clinical research is needed to identify the ideal patient subgroups who receive maximum benefit with the MitraClip therapy. Several current and planned studies such as REALISM, EXPAND, MitraClipANZ, PREMISE, and ACCESS-EU are expected to help identify such subgroup.

In a systematic review and meta-analysis, Giannini et al. (2018) reported survival outcomes of MitraClip with those of medical therapy in patients with functional MR. A total of six eligible observational studies including 2121 participants. MitraClip (n=833) or conservative therapy (n=1288) were included. Four studies exclusively enrolled patients with functional MR while the remaining studies included both functional and degenerative MR. Patients enrolled were predominantly male (78%) and characterized by advance age (median age 71 years), high estimated surgical risk (median logistic EuroSCORE 21% and median Society of Thoracic Surgeons score 11%) and a high burden of co-morbidities (i.e. chronic kidney disease 45%, chronic obstructive pulmonary disease 45%, diabetes mellitus 45%, a history of previous myocardial infarction 25%, and percutaneous coronary intervention 49%). Despite optimal medical therapy, all patients were symptomatic for dyspnea, with 95% in New York Heart Association Class III–IV. The mechanism of MR was functional in 93% of patients with 67% of ischemic etiology. The primary outcome was death by any cause. The secondary outcome was freedom from readmission. Median follow-up was 400 days. MitraClip, when compared with medical therapy (p=0.005), was associated with significant reduction of death (p=0.002) and of readmission due to cardiac disease. At patient-level analysis, including 344 patients, MitraClip confirmed survival benefit over medical therapy for all patients with functional MR and among the most important subgroups. Adverse events included profuse bleeding that required multiple transfusions 13% (9–20%), whereas the incidence of new onset of atrial fibrillation occurred in 1% (0.5–4%). Reported limitations included lack of randomized controlled trials (RCTs) and the study included a wide spectrum of high-risk patients with both functional and degenerative MR. The authors concluded that compared with conservative treatment, MitraClip is associated with a significant survival benefit. This superiority is particularly pronounced among patients with functional MR and across all the main subgroups.

In a systematic review and meta-analysis, De Rosa et al. (2018) reported long-term survival, clinical status, and echocardiographic findings of patients with severe functional mitral regurgitation (FMR) undergoing MitraClip (MC) treatment and to explore the role of baseline features on outcome. A total of 23 studies were included (n=3,253). Only six studies reported the primary endpoint data at two-year follow-up. The in hospital death rate was 2.31%, whereas the mortality rate was 5.37% at 1 month, 11.87% at 6 months, 18.47% at one year and 31.08% at two years. Mitral regurgitation Grade <3+ was observed in 92.76% patients at discharge and in 83.36% patients at follow-up. At follow-up, 76.63% of patients NYHA Class I–II and there were significant improvements in left ventricular (LV) volume, ejection fraction, and pulmonary pressure. Atrial fibrillation had a statistically significant negative effect on one year survival and on the reduction in left ventricular end-diastolic and end-systolic volume. Study limitations included one unpublished study presented at an international congress and only one study had a randomized design. Therefore, the heterogeneity observed for some results, such as the reduction in LVEF at follow-up, may reflect differences between the study cohorts included in the meta-analysis. The authors concluded that in patients with heart failure and severe functional MR, TMVr with MitraClip is safe and results in a durable MR reduction associated with significant clinical and echocardiographic improvement. Despite the need for confirmation by randomized studies, the results of this analysis suggest good performance of MitraClip in terms of all-cause mortality in this particularly high-risk population.

Takagi et al. (2017) reported results of comparative studies of MitraClip versus surgical repair for mitral regurgitation (MR) in a systematic review and meta-analysis. Eligible studies were randomized controlled or observational comparative studies of MitraClip versus surgical repair enrolling patients with MR and reporting early (30-day or in-hospital) or late (≥six-month including early) all-cause mortality. The MR etiology was mixed including degenerative and functional. A total of seven studies (n=1015), six observational (non-randomized) comparative studies and only one RCT (EVEREST II), comparing MitraClip with surgical repair with MR were included in this systematic review and meta-analysis. The late follow-up duration was from 180 days to five years. The authors reported no statistically significant difference in early and late-mortality between the two groups and significantly higher incidence (4.8-fold) of recurrent MR in the MitraClip than surgical repair group.

Philip et al. (2014) reported results of a systematic review of studies evaluating MitraClip or surgical mitral valve (MV) repair or replacement for severe symptomatic mitral regurgitation (MR) in patients at high surgical risk (logistic EuroSCORE >18 or >10). The review included 21 observational studies which used MitraClip (n=3198
patients) and surgical MV repair (n=490) or MV replacement (n=2775). MitraClip patients had a mean Society of Thoracic Surgeons Score (STS) score of 14 and a mean EuroSCORE of 23. Acute procedural success did not differ significantly between groups. However, the 30-day pooled technical failure rate was 3.2% for MitraClip patients, compared with 0.6% for surgical repair/replacement patients (p=0.002). In pooled analysis, the 30-day mortality rate was 3% among MitraClip patients and 16% in surgical repair/replacement patients. Of the total sample, one year data were available for 1064 MitraClip patients (one year data for surgical repair patients was limited to 47 patients and was not reported). Overall, among MitraClip patients, the one year mortality rate was 13.0%, the one year stroke rate was 1.6%, and the need for repeat MV surgery was 1.3%. Over 70% of patients in the MitraClip group had severe, symptomatic MR with baseline NYHA class of III and IV. However, at six months and 1 year over 55% had less than moderate MR (<2+) and were in NYHA class II or lower. On average, 5% of the patients continued to have severe MR (>4+) and <20% were in NYHA class III or IV despite MitraClip implantation. The authors reported that "implantation of the MitraClip can be safely and effectively accomplished in patients with severe MR at high risk for surgical mortality. Mitral valve surgery is technically feasible but is associated with a higher rate of short term adverse events that impacts mortality. Findings from this review should inform clinical decision makers about the adverse event rates associated with mitral valve surgery and MitraClip in these high-risk patient subsets".

Professional Societies/Organizations: The 2017 focused update to the AHA/ACC Practice Guideline for the Management of Patients with Valvular Heart Disease maintains the following recommendation related to the use of transcatheter MV repair for 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 but who have a prohibitive surgical risk because of severe comorbidities and remain severely symptomatic despite optimal guideline-directed medical therapy for heart failure. (Class IIb; Level of Evidence: B)

The Guideline states that "A RCT of percutaneous mitral valve repair using the MitraClip device versus surgical mitral repair was conducted in the United States. The clip was found to be safe but less effective than surgical repair because residual MR was more prevalent in the percutaneous group. However, the clip reduced severity of MR, improved symptoms, and led to reverse LV remodeling". The guideline does not address transcatheter mitral valve replacement (Nishimura, et al., 2014, 2017).

The Guideline states that "chronic severe secondary MR adds volume overload to a decompensated LV and worsens prognosis. However, there are only sparse data to indicate that correcting MR prolongs life or even improves symptoms over an extended time. Percutaneous mitral valve repair provides a less invasive alternative to surgery but is not approved for clinical use for this indication in the United States. The results of randomized controlled trials (RCTs) examining the efficacy of percutaneous mitral valve repair in patients with secondary MR are needed to provide information on this patient group" (Nishimura, et al., 2017).

Hayes Medical Technology Report: A 2018 Hayes, Inc. Medical Technology Directory Comparative Effectiveness Review, Percutaneous Mitral Valve Repair summarized the clinical evidence stating that "A single randomized controlled trial (RCT), the EVEREST II RCT found that patients who are candidates for conventional open surgery had some minor short-term benefits such as reduced need for transfusion, but these perioperative benefits did not outweigh the longer-term risks of need for additional surgery and recurrence of MR. One nonrandomized study found no differences in survival outcomes between high-risk patients treated with the MitraClip and those treated with open surgery. In high-risk patients who are not acceptable candidates for surgery, six nonrandomized studies that compared MitraClip implantation with optimal medical management found benefits such as improved scores of heart function and improved survival after the MitraClip procedure; however, RCTs are needed to confirm these promising findings. Two studies compared MitraClip implantation with minimally invasive open surgery and one study compared the Carillon system with usual care, but these nonrandomized studies do not provide sufficient evidence to support conclusions about relative efficacy" (Hayes, 2018: annual review 2019).

A recent UpToDate document on management of chronic primary mitral regurgitation recommends percutaneous mitral valve repair for patients with prohibitive surgical risk because of severe comorbidities who are severely
symptomatic patients (New York Heart Association class III to IV) despite optimal guideline-directed medical therapy with chronic severe primary MR (stage D) and who have a reasonable life expectancy and favorable anatomy for transcatheter repair (Gaasch, 2019).

A recent UpToDate document on transcatheter mitral valve repair (TMVR) reports that based on evidence in patients with primary MR, TMVR using the MitraClip device is less effective at reducing MR than mitral surgery, with subsequent surgery for mitral valve dysfunction at one year more common after TMVR. On the other hand, major post procedural adverse events are less frequent with TMVR. Clinical studies have demonstrated reduction in the severity of primary MR, reduced left ventricular and left atrial volumes, and improved exercise capacity and quality of life in patients treated with the MitraClip device (Armstrong, et al., 2019).

A recent UpToDate document on management and prognosis of chronic secondary mitral regurgitation recommends that for most patients with moderate-to-severe or severe (3+ to 4+) chronic secondary MR with LVEF ≤50 percent and New York Heart Association (NYHA) functional class II, III, or IVa (ambulatory) HF despite optimum evidence-based management (pharmacologic therapy plus cardiac resynchronization therapy, as indicated), suggest referral to a heart valve team to assess the feasibility and potential benefit and risk of transcatheter mitral valve repair (TMVR). For some patients durable TMVR is not feasible or appropriate due to technical issues, life expectancy (with TMVR) is less than one year, or comorbidities limiting the likelihood of improvement in the patient’s quality of life. Recommendations for TMVR for secondary MR are evolving as randomized trials were completed after publication of major society guidelines (Gaasch, 2019).

Summary: Percutaneous Mitral Valve Repair: A large RCT with five years of follow-up found that patient survival and reduction in degenerative MV regurgitation were similar for the MitraClip procedure versus conventional open surgery. However, additional MV surgery was needed for 28% of MitraClip group patients versus 9% of conventional surgery group patients, a statistically significant difference that seems to outweigh the benefits of avoidance of open heart surgery in this patient population. On the other hand, major post procedural adverse events are less frequent with percutaneous mitral valve repair. This approach has become an option for patients with significant symptomatic mitral regurgitation (MR ≥ 3+) due to primary abnormality of the mitral apparatus (degenerative MR) in patients who have been determined to be at prohibitive risk for mitral valve surgery by a heart team which includes a cardiac surgeon experienced in mitral valve surgery and a cardiologist experienced in mitral valve disease, and in whom existing comorbidities would not preclude the expected benefit from reduction of the MR.

Appropriate patient selection criteria in terms of MR etiology for percutaneous mitral valve repair (functional MR) has not been well-established. Two randomized controlled trials assessing the efficacy of TMVR using the MitraClip compared with continued medical therapy alone in patients with secondary MR yielded different results. The evidence is insufficient to determine the effects of the technology.

Transcatheter Mitral Valve Replacement (MVR): Transcatheter mitral valve replacement (MVR) is being investigated as an alternative for patients with severe mitral valve disease who are poor candidates or have increased risk for conventional mitral valve surgery. Several transcatheter mitral valve replacement (MVR) devices are under development with ongoing clinical trials. One device is the PermaValve™ (MicroInterventional Devices, Inc., Newtown, PA) transcatheter MVR device which is under investigation in the United States. There are currently no FDA-approved devices for transcatheter MVR. This field is at an early stage, and progress will be significantly slower than the development of TAVR due to the complexity of the mitral valve anatomy and pathology. Challenges exist with the currently available technology. Improved and less bulky valve designs and delivery methods may improve technical success. A better understanding of the kind of anticoagulation needed for transcatheter MVR being developed. Optimizing the patient-selection process by using multimodality imaging tools to accurately measure the annulus size and evaluate the risk of LVOT obstruction is essential to minimize complications (Armstrong, et al., 2019; Guerrero, et al., 2017; Regueiro, et al., 2017b; Ramwali, et al., 2016; De Backer, et al., 2014). Evidence in the peer-reviewed literature is limited to case series and registry data with very small numbers of patients. Further studies with a larger number of patients and longer follow-up are needed to determine device durability and the ideal candidates for MVR (Regueiro, et al., 2017a; Guerrero, et al., 2016; Puri, et al., 2016).

Tricuspid Valve
Primary tricuspid valve disease is rare. The underlying etiology can be of either congenital or of acquired nature. Surgical treatment is often reserved for advanced stages of tricuspid disease when dysfunction, particularly in patients with congestive heart failure, has led to symptomatic right heart failure. Patients undergoing tricuspid repair or replacement procedures tend to be at higher risk with poorer outcome. A transcatheter approach for tricuspid valve repair or replacement is being investigated. Patient selection criteria for percutaneous tricuspid valve replacement are based on limited data. Presently there are no FDA-approved devices to be delivered in the tricuspid position. Edwards Lifesciences was awarded CE Mark approval for the Cardioband transcatheter tricuspid valve system on April 30, 2018 (Hayes, 2019; Wagner, et al., 2015; 2016).

Centers for Medicare & Medicaid Services (CMS)
- National Coverage Determinations (NCDs): Multiple NCDs. Refer to the NCD table of contents link in the reference section.
- Local Coverage Determinations (LCDs): No LCDs found.

Use Outside the U.S.
The Edwards SAPIEN Transcatheter Aortic Heart Valve received CE mark certification in 2007, permitting commercial distribution in Europe. The device is also included in Health Canada’s Medical Device Active License listing. According to the FDA summary, the device is approved for distribution in the 27 member states under the European Union, Croatia, Iran, Israel, Jordan, Kuwait, Monaco, Norway, Russia, Saudi Arabia, Singapore, South Africa, Switzerland, Thailand and Turkey.

The Medtronic Melody Transcatheter Pulmonary Valve (TPV) received CE mark certification permitting commercial distribution in Europe in 2006. The Melody system is also included in Health Canada’s Medical Device Active License listing.

The Edwards SAPIEN Pulmonic Transcatheter Heart Valve received CE mark certification in 2010, permitting commercial distribution in the Europe Union for placement in the pulmonary position.

According to the FDA summary, the current Medtronic CoreValve System is commercially available in over 50 countries.

CoreValve (Medtronic) is approved in Europe for use in intermediate-risk patients.

Several additional devices have received CE mark approval and are available outside the U.S., including but not limited to the following:
- Direct Flow Medical transcatheter valve
- JenaValve™ Transapical TAVI system (JenaValve Inc., Munich Germany)
- Engager™ Transcatheter Valve (Medtronic, Minneapolis MN)
- Lotus Valve System (Boston Scientific, Marlborough MA)
- Portico™ Transcatheter Aortic Valve Implantation System (St. Jude Medical, St. Paul, MN)
- ACURATE TA™ (Symetris, Switzerland)

European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS): The 2017 updated ESC/EACTS Guidelines on the Management of Valvular Heart Disease address recommendations for transcatheter aortic valve implantation (TAVI) and mitral valve repair. These guidelines do not address percutaneous pulmonary valve implantation (Falk, et al., 2017).

The indications for intervention in aortic stenosis and recommendations for the choice of intervention mode state in the section on the choice of intervention in symptomatic aortic stenosis:
- TAVI is recommended in patients who are not suitable for SAVR as assessed by the Heart Team (Class I/Level B)
- In patients who are at increased surgical risk (STS or EuroSCORE II >4% or logistic EuroSCORE I >10% or other risk factors not included in these scores such as frailty, porcelain aorta, sequelae of chest radiation), the decision between SAVR and TAVI should be made by the Heart Team according to the
individual patient characteristics, with TAVI being favored in elderly patients suitable for transfemoral access (Class I/Level B)

The guideline further states that the available data from randomized controlled trials and large registries in elderly patients at increased surgical risk show that TAVI is superior in terms of mortality to medical therapy in extreme-risk patients (Leon, et al., 2010), non-inferior or superior to surgery in high-risk patients (Deeb, et al., 2016; Smith, et al., 2011; Mack, et al., 2015; Adams, et al., 2014) and and non-inferior to surgery and even superior when transfemoral access is possible in intermediate-risk patients (Thyregod, et al., 2015; Leon, et al., 2016; Thourani, et al., 2016; Siontis, et al., 2016; Reardon, et al., 2017).

The recommendations for indications for intervention in severe primary mitral regurgitation state:

- 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 (Class IIb/Level C).

The guideline further states that transcatheter mitral valve interventions have been developed to correct primary mitral regurgitation either through a transseptal or a transapical approach. Among the transcatheter procedures, currently only the edge-to-edge mitral repair is widely adopted. Transcatheter mitral valve treatment should be discussed by the Heart Team in symptomatic patients who are at high surgical risk or are inoperable. Percutaneous edge-to-edge repair is generally safe and can improve symptoms and provide reverse LV remodeling. However, the rate of residual mitral regurgitation up to 5 years is higher than with surgical repair.

**National Institute for Health and Clinical Excellence (NICE) (United Kingdom)**

NICE Interventional Procedure Guidance on transcatheter aortic valve implantation for aortic stenosis, updated in July 2017 includes the following recommendations:

- Current evidence on the safety and efficacy of transcatheter aortic valve implantation (TAVI) for aortic stenosis is adequate to support the use of this procedure provided that standard arrangements are in place for clinical governance, consent and audit.
- Details of all patients should be entered into the UK TAVI registry. Adverse events should be reported to the Medicines and Healthcare products Regulatory Agency.
- During the consent process patients should be told about all treatment options and their advantages and disadvantages.
- Patient selection should be carried out by an experienced multidisciplinary team, which must include interventional cardiologists experienced in the procedure, cardiac surgeons, an expert in cardiac imaging and, when appropriate, a cardiac anesthetist and a specialist in elderly medicine. The multidisciplinary team should determine the risk level for each patient and the TAVI device most suitable for them.
- TAVI is a technically challenging procedure that should only be done in specialized centers and only by clinicians and teams with special training and experience in complex endovascular interventions. Units doing this procedure should have both cardiac and vascular surgical support for the emergency treatment of complications and subsequent patient care.

NICE Interventional Procedure Guidance on percutaneous pulmonary valve implantation for right ventricular outflow tract dysfunction, updated in January 2013, includes the following recommendations:

- The evidence on percutaneous pulmonary valve implantation (PPVI) for right ventricular outflow tract (RVOT) dysfunction shows good short-term efficacy. There is little evidence on long-term efficacy but it is well documented that these valves may need to be replaced in the longer term. With regard to safety there are well-recognized complications, particularly stent fractures in the longer term, which may or may not have clinical effects. Patients having this procedure are often very unwell and might otherwise need open heart surgery (typically reoperative) with its associated risks. Therefore, this procedure may be used with normal arrangements for clinical governance, consent and audit.
• The procedure should be performed only in specialist units and with arrangements in place for cardiac surgical support in the event of complications.

• Patient selection should be carried out by a multidisciplinary team including a cardiologist with a special interest in congenital heart disease, an interventional cardiologist and a cardiothoracic surgeon with a special interest in congenital heart disease.

• This is a technically challenging procedure that should be performed only by clinicians with training and experience in interventional cardiology and congenital heart disease.

Updated NICE Interventional Procedure (IP) Guidance on percutaneous mitral valve leaflet repair for mitral regurgitation recommends that:

• Current evidence on the safety and efficacy of percutaneous mitral valve leaflet repair for mitral regurgitation is adequate to support the use of this procedure, in patients for whom open surgery is contraindicated following risk assessment, provided that standard arrangements are in place for clinical governance, consent and audit.

• Patient selection should be done by a multidisciplinary structural heart team, typically including an interventional cardiologist, an expert in transesophageal echocardiography, an expert in heart failure, a cardiac anesthetist, a cardiac surgeon and a specialist nurse.

• Percutaneous mitral valve leaflet repair for mitral regurgitation should only be done in specialized centers with access to both cardiac surgical and vascular surgical support in case emergency treatment of complications is needed.

• This procedure should only be done by clinicians with specialist training and supervision by an experienced mentor for at least the first 20 procedures.

• Clinicians should enter details about all patients having percutaneous mitral valve leaflet repair for mitral regurgitation onto the National Institute for Cardiovascular Outcomes Research database.

This NICE IP overview is based on over 10,000 patients. The studies consist of 3 randomized controlled trials (RCTs), 4 single-arm observational studies, 3 systematic reviews, 3 comparative observational studies, and 3 case reports (NICE, 2019).

Updated NICE Interventional Procedure Guidance on valve-in-valve TAVI for aortic bioprosthetic valve dysfunction states that for patients with aortic bioprosthetic valve dysfunction for whom SAVR is considered to be unsuitable, the evidence on the safety and efficacy of valve-in-valve (ViV) TAVR is adequate. The committee comments that the longer-term evidence for valve-in-valve transcatheter aortic valve implantation (ViV-TAVI) is from earlier-generation TAVI devices and the technology is evolving. Longer-term evidence is needed and this should be taken into account by the multidisciplinary team. (NICE, 2019).

NICE Interventional Procedure Guidance on transapical transcatheter valve-in-valve implantation for a failed surgically implanted mitral valve bioprosthesis states that the current evidence on the safety of transapical transcatheter mitral valve-in-valve implantation for a failed surgically implanted mitral valve bioprosthesis shows the potential for serious complications. However, this is in patients for whom open surgical valve implantation is unsuitable, who have severe symptoms and a high risk of death. The evidence on efficacy shows generally good symptom relief in the short term, but is based on very small numbers of patients. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research (NICE, 2015).

**Coding/Billing Information**

**Note:** 1) This list of codes may not be all-inclusive.
   2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Aortic Valve Implantation**
Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>33361</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach</td>
</tr>
<tr>
<td>33362</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach</td>
</tr>
<tr>
<td>33363</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach</td>
</tr>
<tr>
<td>33364</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach</td>
</tr>
<tr>
<td>33365</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)</td>
</tr>
<tr>
<td>33366</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)</td>
</tr>
<tr>
<td>33367</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>33368</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>33369</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)</td>
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Pulmonary Valve Implantation

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

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<th>CPT® Codes</th>
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<td>33477</td>
<td>Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed</td>
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Mitral Valve Repair or Replacement

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

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<th>Description</th>
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<td>33418</td>
<td>Transcatheter mitral valve repair; percutaneous approach, including transseptal puncture when performed; initial prosthesis</td>
</tr>
<tr>
<td>33419</td>
<td>Transcatheter mitral valve repair; percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)</td>
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</table>

Considered Experimental/Investigational/Unproven:

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<th>CPT® Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0345T</td>
<td>Transcatheter mitral valve repair percutaneous approach via the coronary sinus</td>
</tr>
<tr>
<td>0483T</td>
<td>Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed</td>
</tr>
<tr>
<td>0484T</td>
<td>Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)</td>
</tr>
<tr>
<td>0543T</td>
<td>Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae</td>
</tr>
</tbody>
</table>
0544T  Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture

**Tricuspid Valve Repair or Replacement**

**Considered Experimental/Investigational/Unproven:**

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0545T</td>
<td>Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach</td>
</tr>
</tbody>
</table>

**Cerebral Protection Device**

**Considered Experimental/Investigational/Unproven:**

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37999</td>
<td>Unlisted procedure, vascular surgery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1884</td>
<td>Embolization protective system</td>
</tr>
</tbody>
</table>


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### Appendix A: Current Treatment Recommendations for Patients With Aortic Stenosis
(ACCF/AATS/SCAI/STS Expert Consensus Document on Transcatheter Aortic Valve Replacement (TAVR); Holmes et al., 2012)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Indication</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgical Aortic Valve Replacement</strong></td>
<td>• Symptomatic severe AS (Class I, LOE: B)</td>
<td>• Mortality (3%)</td>
</tr>
<tr>
<td></td>
<td>• Severe AS undergoing CABG, aortic surgery or other valve surgery (Class I, LOE: C)</td>
<td>• Stroke (2%)</td>
</tr>
<tr>
<td></td>
<td>• Symptomatic moderate AS undergoing CABG, aortic surgery or other valve surgery (Class IIa, LOE: C)</td>
<td>• Prolonged ventilation (11%) Thromboembolism and bleeding</td>
</tr>
<tr>
<td></td>
<td>• Asymptomatic severe AS with hypotensive response to exercise (Class IIb; LOE: C)</td>
<td>• Prosthetic dysfunction</td>
</tr>
<tr>
<td></td>
<td>• Asymptomatic extremely severe AS (AVA &lt;0.6 cm², mean gradient &gt;50 mm)</td>
<td>• Perioperative complications are higher when surgical AVR is combined with CABG</td>
</tr>
<tr>
<td><strong>Transcatheter Aortic Valve Replacement</strong></td>
<td>• TAVR is recommended in patients with severe, symptomatic, calcific stenosis of a trileaflet aortic valve who have aortic and vascular anatomy suitable for TAVR and a predicted survival &gt;12 months, and who have a prohibitive surgical risk as defined by an estimated 50% or greater risk of mortality or irreversible morbidity at 30 days or other factors such as frailty, prior radiation therapy, porcelain aorta, and severe hepatic or pulmonary disease. TAVR is a reasonable alternative to surgical AVR in patients at high surgical risk (PARTNER Trial Criteria: STS ≥ 8%*)</td>
<td>Mortality (3% to 5%) Stroke (6% to 7%) Access complications (17%) Pacemaker insertion 2% to 9% (SAPIEN) 19% to 43% (CoreValve) Bleeding Prosthetic dysfunction Paravalvular AR Acute kidney injury Other Coronary occlusion Valve embolization Aortic rupture</td>
</tr>
<tr>
<td><strong>Medical Therapy</strong></td>
<td>• No specific therapy for asymptomatic AS</td>
<td>• Hemodynamic instability</td>
</tr>
<tr>
<td></td>
<td>• Medical therapy not indicated for symptomatic severe AS risk factors as indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Statins not indicated for preventing progression of AS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diuretics, vasodilators and positive inotropes should be avoided in patients awaiting surgery because of risk of destabilization</td>
<td></td>
</tr>
</tbody>
</table>

**Key:**
- **Class I:** Conditions for which there is evidence for and/or general agreement that the procedure or treatment is beneficial, useful, and effective;
- **Class II:** Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment
- **Class IIa:** Weight of evidence/opinion is in favor of usefulness/efficacy
*The original PARTNER protocol specified inclusion criteria as a minimum STS-predicted risk of mortality of ≥ 10. During the trial enrollment phase, the minimum STS-predicted risk of mortality was changed to ≥ 8. In both instances, two surgeons had to document that the true predicted risk of mortality was ≥ 15.

AR indicates aortic regurgitation; AS, aortic stenosis; AVR, aortic valve replacement; CABG, coronary artery bypass graft; LOE, level of evidence; STS, Society of Thoracic Surgeons; and TAVR, transcatheter aortic valve replacement.