



## Valvular Heart Disease

### **I. Policy**

University Health Alliance (UHA) will reimburse for the medical and surgical (including transcatheter procedures) treatment of valvular heart disease (VHD) when determined to be medically necessary (as defined by Hawaii Revised Statutes) and when observant of standard criteria as currently defined. Evidence of shared decision making, decision analysis, institutional competency, post procedure analysis, and an authentic multidisciplinary approach to VHD are requirements for coverage.

### **II. Background**

Options in the treatment of VHD have evolved rapidly. UHA endorses and observes the 2020 ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease.

### **III. Criteria/Guidelines**

- A. Disease stages in patients with valvular heart disease should be classified (Stages A, B, C, and D) based on symptoms, valve anatomy, the severity of valve dysfunction, and the response of the ventricle and pulmonary circulation.
- B. In the evaluation of a patient with valvular heart disease, history and physical examination findings should be correlated with the results of noninvasive testing (ie, ECG, chest x-ray, transthoracic echocardiogram). If there is discordance between the physical examination and initial noninvasive testing, consider further noninvasive (computed tomography, cardiac magnetic resonance imaging, stress testing) or invasive (transesophageal echocardiography, cardiac catheterization) testing to determine optimal treatment strategy.
- C. For patients with valvular heart disease and atrial fibrillation (except for patients with rheumatic mitral stenosis or a mechanical prosthesis), the decision to use oral anticoagulation to prevent thromboembolic events, with either a vitamin K antagonist or a non-vitamin K antagonist anticoagulant, should be made in a shared decision-making process based on the CHA2 DS2 -VASc score. Patients with rheumatic mitral stenosis or a mechanical prosthesis and atrial fibrillation should receive oral anticoagulation with a vitamin K antagonist.
- D. All patients with severe valvular heart disease being considered for valve intervention should be evaluated by a multidisciplinary team, with either referral to or consultation with a Primary or Comprehensive Valve Center.
- E. Treatment of severe aortic stenosis with either a transcatheter or surgical valve prosthesis should be based primarily on symptoms or reduced ventricular systolic function. Earlier intervention may be considered if indicated by results of exercise testing, biomarkers, rapid progression, or the presence of very severe stenosis.
- F. Indications for transcatheter aortic valve implantation are expanding because of multiple randomized trials of transcatheter aortic valve implantation versus surgical aortic valve replacement. The choice of type of intervention for a patient with severe aortic stenosis should be a shared decision-making process that considers the lifetime risks and benefits associated with type of valve (mechanical versus bioprosthetic) and type of approach (transcatheter versus surgical).

- G. Indications for intervention for valvular regurgitation are relief of symptoms and prevention of the irreversible long-term consequences of left ventricular volume overload. Thresholds for intervention now are lower than they were previously because of more durable treatment options and lower procedural risks.
- H. A mitral transcatheter edge-to-edge repair is of benefit to patients with severely symptomatic primary mitral regurgitation who are at high or prohibitive risk for surgery, as well as to a select subset of patients with secondary mitral regurgitation who remain severely symptomatic despite guideline-directed management and therapy for heart failure.
- I. Patients presenting with severe symptomatic isolated tricuspid regurgitation, commonly associated with device leads and atrial fibrillation, may benefit from surgical intervention to reduce symptoms and recurrent hospitalizations if done before the onset of severe right ventricular dysfunction or end-organ damage to the liver and kidney.
- J. Bioprosthetic valve dysfunction may occur because of either degeneration of the valve leaflets or valve thrombosis. Catheter-based treatment for prosthetic valve dysfunction is reasonable in selected patients for bioprosthetic leaflet degeneration or paravalvular leak in the absence of active infection.

**NOTE:**

*This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.*

*Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.*

*UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria considering any supporting documentation through direct peer communication.*

### **III. Administrative Guidelines**

- A. Prior authorization is not required.
- B. UHA reserves the right to perform retrospective review using the above criteria to validate that services rendered met payment determination.
- C. For Aortic Stenosis:
  - 1. Evidence of consideration of a variety of factors including, but not limited to age, life expectancy, a favorable ratio of expectancy to valve durability, frailty or the absence thereof, the degree of aortic stenosis, its etiology (e.g. bivalved, subaortic calcification, or a severely calcified ascending aorta, rheumatic, large or small annulus vs calcific AS of a trileaflet valve,) associated CAD amenable to CABG, prior cardiac surgery, and patient specific goals of care as well as adequacy of transfemoral access, must be documented.
  - 2. The timing of intervention for AS with reference to the stages of the disease, should be explicitly addressed in the documentation.
- D. For Mitral Regurgitation:

1. Evolving transcatheter approaches (e.g., edge to edge MV repair) do not supplant optimal guideline directed medical therapy for patients with chronic severe secondary MR related to LV dysfunction with NYHA class II-IV. Documentation must exist that surgical or transcatheter therapeutic decisions are based upon the stages of secondary MR, valvular anatomy, LVEF and failed GDMT and other general considerations as outline for AS.

#### ***IV. Policy History***

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