



This guidance provides practical direction for integrating transcatheter tricuspid valve therapies into routine cardiovascular practice. It outlines how to structure multidisciplinary evaluation, select appropriate patients for surgery versus transcatheter intervention, meet institutional and operator requirements, comply with Coverage with Evidence Development (CED), and implement registry-based quality monitoring to optimize patient outcomes and program sustainability.

Refer to the full Expert Consensus Systems of Care document for detailed criteria

1 Recognize that symptomatic severe tricuspid regurgitation (TR) is now an interventional disease.

With FDA approval of transcatheter edge-to-edge repair (T-TEER) and transcatheter tricuspid valve replacement (TTVR) in 2024, patients with persistent symptoms despite optimal medical therapy should no longer be managed conservatively by default. Establish a defined referral process for heart team evaluation.

2 Do not default to transcatheter therapy. Reassess surgical candidacy carefully.

Outcomes following isolated tricuspid valve surgery have improved over the past 5–10 years. Evaluate surgical risk systematically and avoid labeling patients “inoperable” without structured assessment and multidisciplinary review.

3 Require formal multidisciplinary heart team adjudication before intervention.

Eligibility for transcatheter tricuspid valve interventions (TTVI) or surgery must be determined by a documented heart team that includes an interventional cardiologist, cardiac surgeon, interventional echocardiographer, advanced imaging specialist, heart failure cardiologist, electrophysiologist, and cardiac anesthesia. Decisions should be consensus-driven and recorded.

4 Integrate imaging as a procedural core function, not a consultative step.

An interventional echocardiographer is a required procedural co-operator for T-TEER and TTVR. Invest in advanced three-dimensional transesophageal echocardiogram expertise and multimodality imaging review to guide patient selection, intraprocedural strategy, and post-procedural assessment.

5 Adhere to defined operator team composition requirements.

Perform T-TEER with at least two physician co-operators, including an interventional echocardiographer. Initiate TTVR programs with three physician operators (interventional echocardiographer, interventional cardiologist, transcatheter-experienced cardiac surgeon), with potential transition to a two-operator model only after meeting established safety and quality benchmarks.

Scan this QR code to access the full CCG for detailed figures and clinical nuance.





6

Meet institutional and case-volume thresholds before launching or sustaining a program.

Follow endorsed criteria from the American College of Cardiology, American Heart Association, American Society of Echocardiography, Heart Rhythm Society, and Society of Thoracic Surgeons regarding facility capabilities, surgical infrastructure, and minimum case volumes. Do not initiate or maintain programs that fall below recommended thresholds.

7

Prepare for Coverage with Evidence Development requirements

Under 2025 policy from the Centers for Medicare & Medicaid Services, T-TEER and TTVR are covered under CED. Track outcomes for a minimum of 24 months, analyze against an active comparator, and ensure complete follow-up that includes patient-reported outcomes to maintain compliance and reimbursement.

8

Participate fully in national registries and use benchmarking proactively

Submit complete data to national registries and review quarterly performance reports. Use funnel plots, risk-adjusted metrics, and complication thresholds to identify early signals of underperformance and implement rapid-cycle quality improvement.

9

Build operational infrastructure for longitudinal care, not just for procedures

Allocate resources for structured preprocedural optimization (heart failure therapy, rhythm management, cardiac implantable electronic device evaluation), standardized follow-up visits, and coordinated postprocedural management. Program success depends as much on patient selection and follow-up as on procedural execution.

10

Expect the field to evolve and build adaptable systems of care

As experience accumulates and new TTVI systems are introduced, recommendations will be revised. Maintain ongoing operator training, reassess team composition when quality benchmarks are achieved, and design workflows that are anatomy- and disease-based rather than device-specific.

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