CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13366	**Date: August 14, 2025**
	Change Request 14200

SUBJECT: NCD 20.38 - Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make contractors aware of coverage for Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) on July 2, 2025.

EFFECTIVE DATE: July 2, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	32/414/Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER)

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13366	Date: August 14, 2025	Change Request: 14200

SUBJECT: NCD 20.38 - Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER)

EFFECTIVE DATE: July 2, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make contractors aware of coverage for Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) on July 2, 2025.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to make contractors aware of coverage for Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) on July 2, 2025. T-TEER is used in the treatment of Tricuspid Regurgitation (TR)

B. Policy: Effective July 2, 2025, the Centers for Medicare & Medicaid Services (CMS) covers Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) under Coverage with Evidence Development (CED) according to the criteria outlined in the NCD manual, Chapter 1, Section 20.38

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14200 - 04.1	Contractors shall allow claims for T-TEER for the treatment of symptomatic tricuspid regurgitation (TR) under CED according to the criteria outlined above. Please refer to the NCD Manual, Publication (Pub.) 100-03, Chapter 1, Section 20.38 for coverage criteria and Pub. 100-04 Chapter 32, Section 414 for claims processing instructions.	X	X			X	X			
14200 - 04.2	Contractors shall process T-TEER claims submitted with International Classification of Diseases, 10th Revision,	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Procedure Coding System (ICD-10-PCS) 02UJ3JZ (Supplement tricuspid valve with Synthetic Substitute, Percutaneous approach) with the following criteria: • Type of Bill (TOB) 11X, and • ICD-10-CM diagnosis Z00.6 (reported as other diagnosis), and • Value code D4 with the 8-digit National Clinical Trial (NCT), and • Condition code 30, and 04 (if appropriate) • ICD-10-CM principal diagnosis is one of the following: • I07.1 • I07.2 • I08.1 • I08.2 • I08.3 • I36.1 • I36.2 • Q22.8 Note: If other procedures are being performed at the same time of the T-TEER, the services will be considered as appropriate and current payment guidelines apply. Note: When submitting claims for T-TEER provided to									

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Medicare Advantage enrollees, hospitals also report condition code 04. Medicare Advantage Organizations are responsible for payment of the service, consistent with Pub. 100-16, chapter 4, section 10.7.3.									
14200 - 04.3	Contractors shall Return to Provider (RTP) T-TEER claims submitted with ICD-10-PCS code 02UJ3JZ and the TOB is not equal to 11X.	X				X				
14200 - 04.4	Contractors shall RTP T-TEER claims submitted with ICD-10-PCS code 02UJ3JZ and condition code 30 is not present.	X				X				
14200 - 04.5	Contractors shall RTP T-TEER claims submitted with ICD-10-PCS code 02UJ3JZ, and value code D4 with the 8-digit NCT is not present.	X				X				
14200 - 04.6	Contractors shall deny T-TEER claims submitted with ICD-10-PCS code 02UJ3JZ, and submitted without one of the following ICD-10-CM principal diagnosis: • I07.1 • I07.2 • I08.1 • I08.2 • I08.3 • I36.1 • I36.2 • Q22.8 and, • ICD-10-CM DX Z00.6 is not required as a	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	principal diagnosis, but it is required on the claim (reported as other diagnosis)									
14200 - 04.6.1	Contractors shall use the following messages when denying claims: Claim Adjustment Reason Code (CARC) 167: This (these) diagnosis(es) is (are) not covered Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD Group Code – CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability Use PR when: • On institutional claims, Occurrence Code 32 is present Medicare Summary Notice (MSN) 15.20: The following	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	policies were used when we made this decision: NCD 20.38 Spanish Version – Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.38									
14200 - 04.7	Contractors shall process T-TEER line-items on professional claims when submitted with Healthcare Common Procedure Coding System (HCPCS) code 0569T (Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis) or 0570T (Each additional prosthesis during same session (List separately in addition to code for primary procedure)) in a clinical research study submitted with the following criteria: ICD-10-CM principal diagnosis is one of the following: • I07.1 • I07.2 • I08.1 • I08.2 • I08.3 • I36.1 • I36.2 • Q22.8, and • ICD-10-CM diagnosis Z00.6 is present (reported as other diagnosis), and		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• NCT is present, and • Q0 modifier is present									
14200 - 04.8	Contractors shall deny T-TEER claims submitted with HCPCS code 0569T or 0570T with the following criteria: • ICD-10-CM principal diagnosis is not equal to • I07.1 • I07.2 • I08.1 • I08.2 • I08.3 • I36.1 • I36.2 • Q22.8 and, • Z00.6 (reported as other diagnosis)		X							
14200 - 04.8.1	Contractors shall deny a line-item on claims with the following messages: CARC 167: This (these) diagnosis(es) is (are) not covered RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to		X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD Group Code – CO or PR dependent upon liability Use PR when: • On professional claims, the GA modifier is appended to a line item with HCPCS 0569T or 0570T MSN 15.20: The following policies were used when we made this decision: NCD 20.38 Spanish Version – Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.38									
14200 - 04.9	Contractors shall return as unprocessable line-items on claims containing HCPCS code 0569T or 0570T in a clinical research study when billed without modifier Q0 using the following messages: CARC 4: The procedure code is inconsistent with the modifier used RARC N519: Invalid combination of HCPCS modifiers		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Group Code: CO									
14200 - 04.10	Contractors shall return as unprocessable line-items on claims containing HCPCS code 0569T or 0570T in a clinical research study when billed without the clinical trial number using the following messages: CARC 16: Claim/service lacks information or has submission/billing error(s) RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or clinical trial number Group Code: CO		X							
14200 - 04.11	Contractors shall not search their files for T-TEER claims processed with DOS or discharge dates between July 2, 2025, and the implementation date of this change request. However, MACs shall adjust those claims that are brought to their attention.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents

(Rev. 13366; Issued: 08-14-25)

414 – T-TEER
(Rev. 13366; Issued: 08-14-25; Effective: 07-02-25; Implementation: 01-05-26)

The Centers for Medicare & Medicaid Services (CMS) covers T-TEER for the treatment of symptomatic tricuspid regurgitation (TR) under Coverage with Evidence Development (CED) according to the criteria outlined in IOM, Pub. 100-03, National Coverage Determination Manual, Ch 1, section 20.38.

414.1 - Coding Requirements for T-TEER
(Rev. 13366; Issued: 08-14-25; Effective: 07-02-25; Implementation: 01-05-26)

The following codes are applicable for T-TEER:

ICD-10-PCS codes 02UJ3JZ (Supplement tricuspid valve with Synthetic Substitute, Percutaneous approach) Healthcare Common Procedure Coding System (HCPCS) code 0569T (Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis) or 0570T (Each additional prosthesis during same session (List separately in addition to code for primary procedure))
ICD-10 diagnosis codes:

- *I07.1*
- *I07.2*
- *I08.1*
- *I08.2*
- *I08.3*
- *I36.1*
- *I36.2*
- *Q22.8 and,*
- *Z00.6 (reported as other diagnosis)*

414.2 – Claims Processing Instructions for T-TEER Professional Claims
(Rev. 13366; Issued: 08-14-25; Effective: 07-02-25; Implementation: 01-05-26)

Professional claims for T-TEER in a clinical research study shall be covered when billed with:

- *HCPCS code 0569T or 0570T*
- *ICD-10 Z00.6 (as other diagnosis code),*
- *the 8-digit clinical trial identifier number,*
- *One of the ICD-10 diagnosis codes listed in section 414.1 as principal diagnosis code*
- *Modifier Q0*

414.3 – Claims Processing Instructions for T-TEER Institutional Claims
(Rev. 13366; Issued: 08-14-25; Effective: 07-02-25; Implementation: 01-05-26)

Inpatient hospitals shall bill for T-TEER on an 11X Type of Bill (TOB).

Inpatient hospital claims for T-TEER shall be covered when billed with:

- *ICD-10-PCS code 02UJ3JZ,*
- *ICD-10 Z00.6 (as other diagnosis code),*
- *Condition Code 30,*
- *Value Code D4 to indicate the 8-digit clinical trial identifier number, and*
- *One of the ICD-10 diagnosis codes listed in section 414.1 as principal diagnosis code*

NOTE: When submitting claims for T-TEER provided to Medicare Advantage enrollees, hospitals also report condition code 04. Medicare Advantage Organizations are responsible for payment of the service, consistent with Pub. 100-16, chapter 4, section 10.7.3.

414.4 – Messages

(Rev. 13366; Issued: 08-14-25; Effective: 07-02-25; Implementation: 01-05-26)

Contractors shall use the following messages when denying claims for T-TEER submitted with missing/incorrect ICD-10 diagnosis code (I07.1, I07.2, I08.1, I08.2, I08.3, I36.1 I36.2, Q22.8 and Z00.6):
CARC 167 – This (these) diagnosis(es) is (are) not covered.
RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at: www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code – CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. Use PR when:

- *On institutional claims, Occurrence Code 32 is present*
- *On professional claims, the GA modifier is appended to a line item with HCPCS 0569T or 0570T.*

MSN 15.20: "The following policies were used when we made this decision: NCD 20.38".

Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.37".

Contractors shall Return to Provider (RTP) claims for T-TEER submitted on TOB other than 11X, or when submitted without condition code 30, or submitted without value code D4 and the 8-digit National Clinical Trial (NCT).

Contractors shall return as unprocessable line-items on claims containing HCPCS 0569T or 0570T code in a clinical research study when billed without modifier Q0 using the following messages:

CARC 4: The procedure code is inconsistent with the modifier used.

RARC N519: Invalid combination of HCPCS modifiers.

Group Code: CO (Contractual Obligation)

Contractors shall return as unprocessable line-items of claims containing HCPCS code 0569T or 0570T in a clinical research study when billed without the clinical trial number using the following messages:

CARC 16: Claim/service lacks information or has submission/billing error(s).

RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or clinical trial number.

Group Code: CO (Contractual Obligation)

NCD:	20.38
NCD Title:	Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=316
	CMS reserves the right to add or remove diagnosis codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.
ICD-10-CM	**ICD-10-CM Description**
	Primary ICD-10 CM codes (when used for symptomatic tricuspid regurgitation (TR) under Coverage with Evidence Development (CED))
I07.1	Rheumatic tricuspid insufficiency
I07.2	Rheumatic tricuspid stenosis and insufficiency
I08.1	Rheumatic disorders of both mitral and tricuspid valves
I08.2	Rheumatic disorders of both aortic and tricuspid valves
I08.3	Combined rheumatic disorders of mitral, aortic and tricuspid valves
I36.1	Nonrheumatic tricuspid (valve) insufficiency - includes Nonrheumatic tricuspid (valve) regurgitation
I36.2	Nonrheumatic tricuspid (valve) stenosis with insufficiency
Q22.8	Other congenital malformations of tricuspid valve
	CED related secondary ICD-10 CM code
Z00.6	Encounter for examination for normal comparison and control in clinical research program

NCD:	20.38
NCD Title:	Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=316
	CMS reserves the right to add or remove diagnosis codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.

ICD-10-PCS	ICD-10-PCS Description
02UJ3JZ	Supplement tricuspid valve with Synthetic Substitute, Percutaneous approach

NCD:	20.38
NCD Title:	Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=316
CR Numbers:	CR14200

Part A	Rule Description Part A	Proposed HCPCS/ CPT/ ICD-10-PCS Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifiers Part A	Provider Specialty	Proposed MSN Messages Part A	Proposed CARC Messages Part A	Proposed RARC Messages Part A
Part A	Effective July 2, 2025, the Centers for Medicare & Medicaid Services (CMS) covers Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) under Coverage with Evidence Development (CED) according to the criteria outlined in the NCD manual, chapter 1, section 20.38. **A/MACs and FISS** shall allow claims for T-TEER for the treatment of symptomatic tricuspid regurgitation (TR) under CED according to the criteria outlined above. Please refer to the NCD Manual, Publication (Pub.) 100-03, Chapter 1, Section 20.38 and Pub. 100-04 Chapter 32, Section 414 for claims processing instructions.	see below	n/a	see below	n/a	n/a	n/a	see below	see below	see below
Part A	**A/MACs and FISS** shall process T-TEER claims submitted with ICD-10-PCS 02UJ3JZ with the following criteria: •Type of Bill (TOB) 11X, and •ICD-10-CM diagnosis Z00.6 (reported as other diagnosis), and •Value code D4 with the 8-digit National Clinical Trial (NCT), and •Condition code 30, and 04 (if appropriate) •ICD-10-CM diagnosis is one of the diagnosis listed under primary list. **Note**: If other procedures are being performed at the same time of the T-TEER, the services will be considered as appropriate and current payment guidelines apply. **Note**: When submitting claims for T-TEER provided to Medicare Advantage enrollees, hospitals also report condition code 04. Medicare Advantage Organizations are responsible for payment of the service, consistent with Pub. 100-16, chapter 4, section 10.7.3.	**02UJ3JZ**	n/a	**11X**	n/a	n/a	n/a	n/a	n/a	n/a
Part A	**A/MACs and FISS** shall Return to Provider (RTP) T-TEER claims submitted with ICD-10-PCS code 02UJ3JZ, with the following criteria: •TOB is not equal to 11X, or •Condition code 30 is not present, or •Value code D4 with the 8-digit NCT is not present.	**02UJ3JZ**	n/a	**11X**	n/a	n/a	n/a	n/a	n/a	n/a
Part A	**A/MACs and FISS** shall deny T-TEER claims submitted with ICD-10-PCS code 02UJ3JZ, with the following criteria: •ICD-10-CM primary diagnosis is not listed, or •Z00.6 (as a secondary) is not present.	**02UJ3JZ**	n/a	n/a	n/a	n/a	n/a	**15.20**	**167**	**N386(CO/PR)**

Part B	Rule Description Part B	Proposed HCPCS/ CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifiers Part B	Provider Specialty	Proposed MSN Messages Part B	Proposed CARC Messages Part B	Proposed RARC Messages Part B
Part B	Effective July 2, 2025, the Centers for Medicare & Medicaid Services (CMS) covers Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) under Coverage with Evidence Development (CED) according to the criteria outlined in the NCD manual, chapter 1, section 20.38. **B/MACs and MCS** shall allow claims for T-TEER for the treatment of symptomatic tricuspid regurgitation (TR) under CED according to the criteria outlined above. Please refer to the NCD Manual, Publication (Pub.) 100-03, Chapter 1, Section 20.38 and Pub. 100-04 Chapter 32, Section 414 for claims processing instructions.	see below	n/a	n/a	n/a	see below	n/a	see below	see below	see below
Part B	**B/MACs and MCS** shall process T-TEER line-items on professional claims when submitted with CPT code 0569T or 0570T in a clinical research study submitted with the following criteria: •ICD-10-CM diagnosis is one of the diagnosis listed under primary list, •ICD-10-CM diagnosis Z00.6 (reported as other diagnosis), •NCT is present, and •Q0 modifier is present.	**0569T** **0570T**	n/a	n/a	n/a	**Q0**	n/a	n/a	n/a	n/a
Part B	**B/MACs** shall deny T-TEER claims submitted with HCPCS code 0569T or 0570T with the following criteria: •ICD-10-CM primary diagnosis is not listed, or •Z00.6 (as a secondary) is not present.	**0569T** **0570T**	n/a	n/a	n/a	n/a	n/a	**15.20**	**167**	**N386 (CO/PR)**
Part B	**B/MACs and MCS** shall return as unprocessable line-items on claims containing HCPCS code 0569T or 0570T in a clinical research study, with the following criteria: •When billed without modifier Q0, or •When billed without the clinical trial number.	**0569T** **0570T**	n/a	n/a	n/a	**Q0**	n/a	n/a	**4** **------** **16**	**N519 (CO)** **------** **MA50 (CO)**
	Revision History									
	CR14200: New spreadsheet created.									