



Bronchial Thermoplasty

Clinical Coverage Criteria

Overview

Asthma is a chronic disease of the lungs in which inflammation causes the bronchi to swell and narrow the airways creating mild to severe chest tightness, coughing, shortness of breath and wheezing. Treatment is dependent on the severity and recurrence of symptoms and usually consists of inhaled corticosteroids and long-acting beta-agonists.

Bronchial Thermoplasty is a minimally invasive treatment approved for adults who's symptoms are not well controlled on inhaled corticosteroids and long-acting beta-agonists. It consists of a controlled amount of radiofrequency which heats the tissues which destroys the smooth muscle lining beneath the bronchial passages resulting in an enhanced inflammatory response and subsequent airway constriction.

Policy

Bronchial Thermoplasty requires prior authorization. These requests must be supported by the treating provider(s) medical records. All the below criteria must be met:

1. The member must be 18 years of age or older.
2. The member has been diagnosed with severe asthma with consistent, daily symptoms resulting in the use of a rescue inhaler such as the below.
 - Wheezing, coughing, chest tightness, and shortness of breath.
 - Persistent nighttime symptoms.
3. The severe symptoms are limiting the member's daily physical activities.
4. The member's symptoms have been treated and medically managed by an Asthma Specialist for a minimum of 6 months.
5. Evidence in the medical records supporting the member's symptoms are not responding to inhaled corticosteroids and long-acting-beta-agonists for a minimum of 3 months for severe asthma exacerbations 2 or more times requiring oral steroids or being considered for chronic oral steroids or requiring hospitalizations.
6. The member is a non-smoker.
7. The member does not have a contraindication to bronchial thermoplasty such as, but not limited to (a pacemaker, active respiratory infection, etc.)

Exclusions

- Any use of Bronchial Thermoplasty other than outlined above.

Codes

Code type	Code	Description
CPT	31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe

	31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes
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References

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9. Zhou JP, Feng Y, Wang Q, Zhou LN, Wan HY, Li QY. Long-term efficacy and safety of bronchial thermoplasty in patients with moderate-to-severe persistent asthma: a systemic review and metaanalysis. *J Asthma*. 2016;53(1):94-100.
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13. Bonta PI, Chanez P, Annema JT, Shah PL, Niven R. Bronchial Thermoplasty in Severe Asthma: Best Practice Recommendations from an Expert Panel. *Respiration*. 2018;95(5):289-300. doi: 10.1159/000488291. Epub 2018 Apr 17.

Policy History

Origination date: 06/01/2018
Approval(s): Technology Assessment Committee: 05/15/2018 (Introduced as a new policy), 05/22/2019 (updated references)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.