

**Subject:** Bronchial Thermoplasty Policy

**Effective Date:** 07/2013

**Review Date:** 08/2017

## **DESCRIPTION**

### A. DESCRIPTION OF BRONCHIAL THERMOPLASTY

Bronchial Thermoplasty is the application of thermal energy directly to the airway smooth muscle through a bronchoscope using the Alair catheter. Thermal energy inhibits smooth muscle contraction in the areas treated. The treatment is performed as an outpatient under conscious sedation or general anesthesia in the bronchoscopy suite. Treatments are applied to specific lung segments (right lower lobe, left lower lobe, bilateral upper lobes) at least 3 weeks apart. The right middle lobe is never treated. Spirometry is performed before and after the procedure to ensure the candidate has returned to baseline before discharge. To limit the amount of inflammation the candidate takes prednisone 50 mg daily for 5 days beginning 3 days before the procedure.

### B. ELIGIBILITY REQUIREMENTS FOR BRONCHIAL THERMOPLASTY

The following information about eligibility applies to all services. A member must meet all of the following eligibility requirements to be covered:

1. The Member must meet eligibility per *Ohio State University, University –Sponsored Medical Plans Specific Plan Details Document*.
2. The Member must meet the following criteria to be considered for bronchial thermoplasty:
  - a. The ordering physician is a pulmonologist
  - b. The Member is 18 years or older and has severe persistent asthma as demonstrated by one or more of the following:
    - i. Use of a rescue inhaler more than 2 days per week
    - ii. Use of a rescue inhaler 2 or more nights a month
    - iii. FEV1 < 60% (off medications)
    - iv. FEV1/FVC reduced > 5%
  - c. The Member is not well controlled according to one of the following validated instruments:
    - i. ACT ≤ 15
    - ii. ATAQ 3-4
    - iii. ACQ ≥ 1.5
  - d. The Member has an increased asthma risk as defined by one or more of the following:
    - i. Oral steroids for exacerbation ≥ 2 times per year
    - ii. Progressive loss of lung function
    - iii. Significant side effects to asthma medications
  - e. The Member is on a medication regimen consistent with level 5 or 6 of the NHLBI asthma guidelines or there is documentation of intolerance or ineffectiveness of any of these medications.
  - f. The Member's asthma has been stable for a minimum of 4 weeks prior to bronchial thermoplasty (e.g., patient has not had any of the following: increased use of rescue inhaler, antibiotics for acute respiratory infections, exacerbations requiring oral steroids).
  - g. The Member demonstrates medication compliance based on pharmacy records and office samples.
  - h. Medical records document the patient has been assessed and potential reversible causes of severe asthma have been ruled out (i.e., poor inhaler technique, inadequate adherence to therapy, exposures to environmental triggers, cigarette smoking)

- i. Co-morbidities such as allergies, sinus disease, vocal cord dysfunction, acid reflux, pulmonary aspergillosis, obstructive sleep apnea have been identified and treated (not an all-inclusive list).
3. Documentation Requirements:
- a. H&P
  - b. Evaluation by pulmonologist
  - c. Progress notes documenting severe persistent asthma as defined
  - d. Other supportive documentation when applicable to the case

**C. EXCLUSIONS:**

The following are absolute contraindications to bronchial thermoplasty (not all inclusive):

- 1. Pacemaker, internal defibrillator or implantable electronic device
- 2. Known coagulopathy
- 3. Known sensitivity to the medications used to perform bronchoscopy (such as lidocaine, atropine, benzodiazepines)
- 4. Previous bronchial thermoplasty treatment (in the area to be treated)
- 5. Unstable co-morbid conditions presenting risk for bronchoscopy
- 6. Pregnancy
- 7. Inability to stop anticoagulants or antiplatelet agents prior to the procedure

**C. CPT CODES COVERED IF SELECTION CRITERIA ARE MET:**

31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe
31661	With bronchial thermoplasty, 2 or more lobes

**E. APPROVAL PROCESS FOR BRONCHIAL THERMOPLASTY**

- 1. An evaluation must be completed and submitted by a **PULMONOLOGIST**.
- 2. Treatment meets the OSU Health Plan’s medical necessity coverage guidelines.

**PRIOR AUTHORIZATION INSTRUCTIONS**

Submit required documentation to the OSU Health Plan

**INDICATIONS FOR NURSE APPROVAL**

Members meeting the established OSU Health Plan criteria.

**REASONS FOR PHYSICIAN REVIEWER DENIAL**

Requirements not met for eligibility.

**REFERENCES**

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