



MASSACHUSETTS

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Medical Policy

Bronchial Thermoplasty

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Policy Number: 284

BCBSA Reference Number: N/A

NCD/LCD: N/A

Related Policies

None

Policy¹

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Bronchial thermoplasty, performed by a pulmonologist who has completed a bronchial thermoplasty training curriculum, may be considered **MEDICALLY NECESSARY** for individuals ≥18 years when the following criteria are met:

- Individual has been diagnosed with severe persistent asthma by having any of the following criteria in the absence of controller medications:
 - Daily symptoms
 - Nighttime awakenings, every night
 - Use of rescue medicine multiple times per day
 - Normal activities are extremely limited
 - Impaired lung function (less than or equal to 60% predicted)
 - Frequent exacerbations, **AND**
- Co-morbid conditions contributing to asthma exacerbations have either been ruled out or fully controlled (e.g., allergy symptoms, GERD), **AND**
- Individual is taking chronic oral corticosteroids, **OR**
- Poor asthma control despite being on high-dose ICS and LABA for a minimum of 3 months with two or more asthma exacerbations per year. Asthma exacerbations are defined as follows:
 - Individual required oral systemic corticosteroid use due to respiratory symptoms, **OR**
 - Urgent provider's office visit due to severe respiratory symptoms, **OR**
 - Emergency department visit due to respiratory symptoms, **OR**
 - Hospitalization due to respiratory symptoms.

Bronchial thermoplasty is **contraindicated** for individuals with the following conditions:

- Presence of a pacemaker, internal defibrillator, or other implantable electronic device
- Known sensitivity to medications required to perform bronchoscopy, including lidocaine, atropine and benzodiazepines
- Individuals previously treated with bronchial thermoplasty
- Active respiratory infection
- Asthma exacerbation or changing dose of systemic corticosteroids for asthma (up or down) in the past 14 days
- Known coagulopathy.

Bronchial thermoplasty is considered **INVESTIGATIONAL** when the above criteria are not met.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is required .
Commercial PPO	Prior authorization is required .
Medicare HMO BlueSM	Prior authorization is required .
Medicare PPO BlueSM	Prior authorization is required .

Requesting Prior Authorization Using Authorization Manager

Providers will need to use [Authorization Manager](#) to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the service request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

Refer to our [Authorization Manager](#) page for tips, guides, and video demonstrations.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The following CPT codes are considered medically necessary when the policy guidelines above are met for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
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

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0B538ZZ	Destruction of Right Main Bronchus, Via Natural or Artificial Opening
0B548ZZ	Destruction of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B558ZZ	Destruction of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B568ZZ	Destruction of Right Lower Lobe Bronchus, Via Natural or Artificial Opening
0B578ZZ	Destruction of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B588ZZ	Destruction of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B598ZZ	Destruction of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic
0B5B8ZZ	Destruction of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic

Description

Asthma demonstrates specific clinical features that include bronchial hyper-responsiveness, airway inflammation and reversible airflow obstruction that cause symptoms of episodic shortness of breath, wheezing, coughing, and chest tightness. Management of asthma consists of environmental control, patient education, management of co-morbidities, and regular follow-up for all affected individuals, as well as a stepped approach to medication treatment. Despite this multidimensional approach, morbidity remains high, and it is believed to be due to the substantial heterogeneity in the inflammatory features of asthmatic patients, yielding variable responses to evidence based treatment.

Bronchial thermoplasty is a procedure, which delivers radiofrequency energy to heat tissues in the distal airways with the ultimate outcome of reducing the amount of smooth muscle to decrease muscle-mediated bronchoconstriction. It is based on the premise that patients with treatment resistant asthma have an increased amount of smooth muscle in the airway resulting in an enhanced inflammatory response and subsequent airway constriction.

Bronchial thermoplasty procedures are performed on an outpatient basis. A standard flexible bronchoscope is placed into the most distal targeted airway. The process is repeated several times along the accessible length of the airway.

An example of bronchial thermoplasty is the Alair Bronchial Thermoplasty System from Asthmatx, Inc. All bronchial thermoplasty procedures are considered investigational regardless of the commercial name, the manufacturer or FDA approval status.

Summary

Three RCTs on bronchial thermoplasty have been published; only one of these, the AIR2 trial had sites in the United States. In the AIR2 trial, bronchial thermoplasty provided benefit in terms of quality of life and some, but not all, secondary outcomes. It is unclear, however, which patients are most likely to respond to treatment. Data from the AIR2 suggests that those with more severe asthma may experience the greatest improvement.

Long-term safety data up to 5 years are available from participants in the AIR trial and do not suggest a high rate of delayed complications following bronchial thermoplasty. However, long-term safety data are not yet available from the two other RCTs, and long-term data on clinical outcomes such as exacerbation rates and quality of life are not available. Other ongoing trials are evaluating predictors of response to treatment. Despite the low volume of published long term data on bronchial thermoplasty, patients with severe persistent asthma who are very poorly controlled despite being on maximum ICS and LABA therapy have few other treatment options. Bronchial thermoplasty may provide improved quality of life by decreasing exacerbation frequency, decreasing the need for systemic corticosteroids and improving asthma symptoms overall. Therefore, bronchial thermoplasty is considered medically necessary.

Policy History

Date	Action
8/2024	Annual policy review. Policy statements unchanged.
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
8/2023	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
8/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
6/2022	Prior authorization information clarified for PPO plans. Effective 6/1/2022.
1/2022	Clarified prior authorization information
8/2020	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
8/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
7/2018	New references added from BCBSA National medical policy. Background and summary clarified.
7/2017	New references added from BCBSA National medical policy.
10/2016	New medically necessary indications described based on expert opinion. Clarified coding information. Effective 10/1/2016.
12/2015	Added coding language.
8/2015	New references added from BCBSA National medical policy.
9/2014	New references added from BCBSA National medical policy.
7/2014	Clarified coding information.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
4/2011	Reviewed - Medical Policy Group – Cardiology and Pulmonology. No changes to policy statements.
11/1/2010	Medical Policy #284 effective 11/1/2010 describing ongoing non-coverage.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

- [Medical Policy Terms of Use](#)
- [Managed Care Guidelines](#)
- [Indemnity/PPO Guidelines](#)
- [Clinical Exception Process](#)
- [Medical Technology Assessment Guidelines](#)

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Endnotes

¹ Based on expert opinion, MPG April 2016