Bronchial Thermoplasty For Treatment of Asthma  

MPM 2.13

Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

Bronchial thermoplasty (BT) is a bronchoscopic procedure that employs radiofrequency ablation to reduce the mass of airway smooth muscle (ASM), thus attenuating bronchoconstriction. Bronchial thermoplasty is performed on an outpatient basis with conscious sedation (i.e., no general anesthesia is needed), and it usually takes approximately one hour to complete. Treatment consists of 3 separate treatments approximately 3 weeks apart.

Bronchial Thermoplasty is used to treat severe, persistent, refractory, asthma that does not improve despite treatment with multiple modalities.

Coverage Determination/Clinical Indications

Bronchial Thermoplasty has been reviewed by the Technology Assessment Committee. Presbyterian considers Bronchial Thermoplasty Investigational and Experimental and there is not enough data to support efficacy therefore it is not covered.

Medical Terms

Asthma – A respiratory disorder, often of allergic origin, characterized by difficulty breathing, wheezing, and a sense of constriction in the chest.

Bronchial – relating to the bronchi (two main branches of the trachea)

Bronchoscope - A thin flexible instrument used to view the air passages of the lungs.

Radiofrequency - Thermal energy of a certain frequency range.

Coding

The coding listed in this Medical Policy is for reference only. Covered and non-covered codes are within this list.

<table>
<thead>
<tr>
<th>CPTCodes</th>
<th>Non-covered CPT</th>
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</thead>
<tbody>
<tr>
<td>31660</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe</td>
</tr>
<tr>
<td>31661</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes.</td>
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</tbody>
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<tr>
<th>ICD-10 Codes</th>
<th>Non covered diagnoses (not all-inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J41.0-J47.9</td>
<td>Chronic lower respiratory diseases and hypersensitivity pneumonitis due to organic dust (including asthma)</td>
</tr>
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<td>J67.0-J67.9</td>
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References


Aetna® Clinical Policy Bulletin, # 0744 Bronchial Thermoplasty, Effective 2/8/08. Last Review 03/12/2019. [Cited 05/01/2019].

Approval Signatures

Clinical Quality Committee: Norman White MD
Medical Director: David Yu MD

Approval Dates

May 22, 2019

Publication History

09-23-15: Original effective date
01-27-16: Annual review. Hayes No Change
03-22-17: Annual Review. Hayes No change in new report. No change. Rating continues to be a C. Milliman has no change documentation does not support use of this technology.
05-22-19 Annual Review. Updated references to reflect new publication from Hayes, MCG and NICE no change still considered experimental and investigational. Add CPT and ICD-10-CM.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. This Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available on the Presbyterian Healthcare Services website at: http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm

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