Medical Policy
Bronchial Thermoplasty

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Policy Number: 284
BCBSA Reference Number: 7.01.127
NCD/LCD: N/A

Related Policies
None

Policy
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 patients ≥18 years when the following criteria are met:

- Patient has been diagnosed with severe persistent asthma by having any of the following criteria in the absence of controller medications:
  - Daily symptoms
  - Night time 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

- Patient 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:
  - Patient 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 patients 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
- Patients 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.

<table>
<thead>
<tr>
<th>Product Type</th>
<th>Prior Authorization Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Required</td>
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<tr>
<td>Commercial PPO and Indemnity</td>
<td>Not required</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>Required</td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>Not required</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<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>
</table>

ICD-10 Procedure Codes

<table>
<thead>
<tr>
<th>ICD-10-PCS procedure code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>0B538ZZ</td>
<td>Destruction of Right Main Bronchus, Via Natural or Artificial Opening</td>
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</table>
### Description

**Asthma**

Asthma, a chronic lung disease, affects approximately 7.7% of adults and 7.5% of children in the U. S. and, in 2018, accounted for approximately 1.6 million emergency department visits and 3564 deaths. Asthma symptoms include episodic shortness of breath that is generally associated with other symptoms such as wheezing, coughing, and chest tightness. Objective clinical features include bronchial hyperresponsiveness, airway inflammation, and reversible airflow obstruction (at least 12% improvement in forced expiratory volume in 1-second post-bronchodilator, with a minimum of 200 mL improvement). However, there is substantial heterogeneity in the inflammatory features of patients diagnosed with asthma, and this biologic diversity is responsible, at least in part, for the variable response to treatment in the asthma population.

**Management**

Management of asthma consists of environmental control, patient education, management of comorbidities, and regular follow-up for affected patients, as well as a stepped approach to medication treatment. Guidelines from the National Heart, Lung and Blood Institute have defined 6 pharmacologic steps: step 1 for intermittent asthma and steps 2 through 6 for persistent asthma. The preferred daily medications: step 1: short-acting b-agonists as-needed; step 2: low-dose inhaled corticosteroids (ICS); step 3: ICS and long-acting b-agonists (LABA) or medium-dose ICS; step 4: medium-dose ICS and LABA; step 5: high-dose ICS and LABA; and step 6: high-dose ICS and LABA, and oral corticosteroids.

Despite this multidimensional approach, many patients continue to experience considerable morbidity. In addition to ongoing efforts to implement optimally standard approaches to asthma treatment, new therapies are being developed. One recently developed therapy is bronchial thermoplasty, the controlled delivery of radiofrequency energy to heat tissues in the distal airways. Bronchial thermoplasty is based on the premise that patients with asthma have an increased amount of smooth muscle in the airway and that contraction of this smooth muscle is a major cause of airway constriction. The thermal energy delivered via bronchial thermoplasty aims to reduce the amount of smooth muscle and thereby decrease muscle-mediated bronchoconstriction with the ultimate goal of reducing asthma-related morbidity. A typical full course of treatment consists of 3, one hour sessions, given 3 weeks apart under moderate sedation. All accessible airways distal to the main stem bronchus that are 3 to 10 mm in diameter are treated once, except those in the right middle lobe; the lower lobes are treated first followed by the upper lung. Bronchial thermoplasty is intended as a supplemental treatment for patients with severe persistent asthma (ie, steps 5 and 6 in the stepwise approach to care).

**Summary**

**Description**

Thermoplasty is a potential treatment option for patients with severe persistent asthma. It consists of radiofrequency energy delivered to the distal airways with the aim of decreasing smooth muscle mass believed to be associated with airway inflammation.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0B548ZZ</td>
<td>Destruction of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>0B558ZZ</td>
<td>Destruction of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>0B568ZZ</td>
<td>Destruction of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>0B578ZZ</td>
<td>Destruction of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>0B588ZZ</td>
<td>Destruction of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>0B598ZZ</td>
<td>Destruction of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>0B5B8ZZ</td>
<td>Destruction of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic</td>
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Summary of Evidence
For individuals who have asthma refractory to standard treatment who receive bronchial thermoplasty added to medical management, the evidence includes 3 RCTs and observational studies. Relevant outcomes are symptoms, QOL, hospitalizations, and treatment-related morbidity. Early studies (RISA, AIR) investigated safety outcomes, finding similar rates of adverse events and exacerbations between the bronchial thermoplasty and control groups. These trials were limited by their lack of sham control. The AIR2 trial is the largest of the 3 published RCTs, and the only 1 double-blinded and sham-controlled, with sites in the U.S. Over 1 year, bronchial thermoplasty was not found to be superior to sham treatment on the investigator-designated primary efficacy outcome of mean change in the QOL score but was found to be superior on a related outcome, improvement in the QOL of at least 0.5 points on the AQLQ. There was a high response rate in the sham group of the AIR2 trial, suggesting a large placebo effect, particularly for subjective outcomes such as QOL. There are no long-term sham-controlled efficacy data. Findings on adverse events from the 3 trials have suggested that bronchial thermoplasty is associated with a relatively high rate of adverse events, including hospitalizations during the treatment period, but not in the posttreatment period. Safety data up to 5 years have been reported in the RCTs for patients treated with bronchial thermoplasty but not for control patients. Data from a U.K. registry showed that 20% of bronchial thermoplasty procedures were associated with a safety event (ie, procedural complications, emergency respiratory readmissions, emergency department visits, and/or postprocedure overnight stays), with uncertain benefit. Conclusions cannot be drawn about the effect of bronchial thermoplasty on the net health outcome due to the limited amount of sham-controlled data (1 RCT) on short-term efficacy, the uncertain degree of treatment benefit in that single sham-controlled trial, the lack of long-term sham-controlled data in the face of a high initial placebo response, and the presence of substantial adverse events. Also, there is a lack of data on patient selection factors for this procedure and, as a result, it is not possible to determine whether there are patient subgroups that might benefit. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>7/2017</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>12/2015</td>
<td>Added coding language.</td>
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<td>8/2015</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>9/2014</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>7/2014</td>
<td>Clarified coding information.</td>
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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
References


Endnotes

1 Based on expert opinion, MPG April 2016