Medical Policy
Bronchial Thermoplasty

Policy Number: 012

<table>
<thead>
<tr>
<th>Authorization required</th>
<th>Commercial and Qualified Health Plans</th>
<th>MassHealth</th>
<th>Medicare Advantage</th>
</tr>
</thead>
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<td>Authorization not required</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Not covered</td>
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Overview
The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine medical appropriateness for bronchial thermoplasty to treat asthma. The treating specialist must request prior authorization for the procedure.

Coverage Guidelines
Bronchial thermoplasty may be considered medically necessary when the request meets the medical necessity criteria indicated below:

1. The member is 18 years of age or older;
2. The member has a clinical diagnosis of severe, chronic asthma, resulting in persistent symptoms including coughing, wheezing, shortness of breath, and frequent nighttime awakenings.
3. The member’s symptoms are limiting normal daily physical activities
4. The member’s symptoms have failed to respond to inhaled corticosteroids or long acting beta agonists for a minimum of 3 months, with two or more asthma exacerbations in the past 12 months
5. The member is a non-smoker
6. Requesting physician must be a pulmonologist

Documentation Requirements
All member requests require an explicit order from the authorized treating pulmonologist including diagnosis and clinical indications.

Exclusions
1. The member has a pacemaker, internal defibrillator, or other implantable electronic device
2. The member has sensitivity to medications required to perform bronchoscopy, including lidocaine, atropine, and benzodiazepines
3. The member has known coagulopathy
4. The member has an activity respiratory infection

Medicare Variation
Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan’s medical policies are used for coverage determinations.
Definitions
Bronchial Thermoplasty: A technique of applying heat (via a device that delivers localized controlled radiofrequency waves) to the airways during bronchoscopy, which reduces the increased mass of airway smooth muscle associated with asthma.

Codes
The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

This list of codes applies to commercial and MassHealth plans only.

<table>
<thead>
<tr>
<th>Authorized CPT/HCPCS 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; w/ bronchial thermoplasty, 1 lobe</td>
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<tr>
<td>31661</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; w/ bronchial thermoplasty, 2 or more lobes</td>
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Effective
April 2023: Annual review. Medicare Advantage added to table. Medicare Variation language added.
April 2022: Annual review. References updated.
April 2021: Annual review.
August 2019: Effective date.

References


