Medical Necessity Guidelines: Bronchial Thermoplasty

Effective: September 18, 2019

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products

☒Tufts Health Plan Commercial products; Fax: 617.972.9409

☒Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Tufts Health Plan may cover bronchial thermoplasty for Members who meet specific guidelines. Bronchial thermoplasty is a minimally invasive treatment that uses heat to weaken and partially destroy the smooth muscle in the lungs that constricts the airway during asthma attacks.

Note: A complete bronchial thermoplasty procedure is performed in three treatment sessions with a recovery period of 3 weeks or longer between sessions. One prior authorization will allow for 3 treatment sessions.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize elective bronchial thermoplasty when ALL of the following are met:

- The Member must be age 18 years or older with a confirmed diagnosis of asthma
- The requesting physician must be a pulmonologist
- The Medical record documentation must include the following:
  - Adherence to maximum tolerated doses of inhaled corticosteroids and long-acting beta antagonists for at least 3 months
  - Treatment currently includes, or the Member is a candidate for, long-term (>3 months) oral corticosteroids
  - For Members with concomitant allergies, the Member has been seen by an allergist for consideration of treatment with Omalizumab
  - The Member continues to experience asthma symptoms after meeting the above criteria, **AND** has had at least 2 asthma exacerbations in the past 12 months, at least one of which required an Emergency Department visit or Hospital Observation/Admission.

CODES

The following CPT codes require prior authorization:

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

REFERENCES

1. Boston Scientific website. Available at: btforasthma.com . Accessed March 3, 2015. Last accessed July 20, 2017.
2. Hayes, Winifred S. Directory. Bronchial thermoplasty for treatment of asthma. April 7, 2014. Available at: hayesinc.com. Accessed March 3, 2015.
3. American College of Chest Physicians (ACCP). Position Statement for Coverage and Payment for Bronchial Thermoplasty. 2014. Available online at: chestnet.org/News/CHEST-News/2014/05/Position-Statement-for-Coverage-and-Payment-for-Bronchial-Thermoplasty. Last accessed July 20, 2017.
4. U.S. Food and Drug Administration (FDA). FDA approves new device for adults with severe and persistent asthma. FDA News. Silver Spring, MD: FDA; April 27, 2010. Accessed March 3, 2015. Available at: fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm209909.htm
5. U.S. Food and Drug Administration (FDA). Alair Bronchial Thermoplasty System-P080032. Summary of safety and effectiveness data. Updated May 19, 2010. Accessed March 3, 2015. Last accessed July 20, 2017.
6. Hayes, Winifred S. Directory. Bronchial thermoplasty for the treatment of asthma. May 26, 2016. Update search Apr 24, 2017.

APPROVAL HISTORY

April 9, 2015: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC) for an effective date of January 1, 2016

Subsequent endorsement date(s) and changes made:

- July 20, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017.
- July 20, 2017: Reviewed by IMPAC, renewed without changes.
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- September 18, 2019: Reviewed by IMPAC, renewed without changes

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.