



IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Bronchial Thermoplasty	Guideline #	UM_SUR 10
		Original Effective Date	May 9, 2018
Section	Surgical Procedures	Revision Date	

COVERAGE POLICY

Bronchial Thermoplasty (BT) may be considered medically necessary when ALL the following criteria are met:

- A. The patient has been managed by an asthma specialist (pulmonologist, allergist, immunologist) for at least six months prior to consideration of BT
- B. The patient is 18 years of age or older
- C. The patient is a current non-smoker
- D. There is documentation that the patient is compliant with preferred asthma medications, and has received training in asthma self-management (e.g., self-monitoring of symptoms and/or Peak Expiratory Flow (PEF), written asthma action plan, and regular medical review).
- E. The patient has been diagnosed with chronic, severe persistent asthma that has failed or not tolerated maximum therapy (defined below);
 1. Severe persistent asthma is defined as:
 - a. Documented current use of an inhaled corticosteroid for at least six consecutive months; AND
 - b. Documented current use of an additional controller medication including long-acting beta agonist, long-acting muscarinic antagonist or leukotriene inhibitor for at least six consecutive months; AND
 - c. Documentation that patient's co-morbidities have been reviewed, addressed and are being treated appropriately; AND
 - d. The patient is taking, or is being considered for, chronic oral corticosteroids to maintain asthma control; AND
 - e. The patient is not a candidate for, or has failed a three month trial of biologic therapy (such as anti-IgE, anti-IL5) with no change in symptom severity
 2. Severe persistent asthma therapy that has not been effective or is not well tolerated is defined by at least one of the following:
 - a. Poor symptom control as evidenced by the presence of greater than or equal to three of the following:
 - i. Daytime asthma symptom more than twice per week
 - ii. Any night waking due to asthma
 - iii. Need for symptom relief more than twice per week
 - iv. Any activity limitation due to asthma
 - b. Asthma Control Test (ACT) less than 20 (Appendix A)
 - c. Two or more serious attacks, hospitalizations, ED visits, or exacerbations requiring systemic corticosteroids within the past 12 months

COVERAGE LIMITATIONS AND EXCLUSIONS

- A. One complete thermoplasty procedure must be performed in three treatment sessions with a recovery period of 2 weeks or longer between sessions.
- B. Repeat procedures of bronchial thermoplasty, beyond the initial three treatments are not covered because it has not been shown to improve long-term health outcomes.
- C. Bronchial thermoplasty is not covered for any other indications than outlined in criteria.
- D. Bronchial thermoplasty must be performed by clinicians experienced in bronchoscopy and who have completed bronchial thermoplasty training and are certified to perform BT by Boston Scientific.
- E. Contraindications
 1. Patients are unable to undergo bronchoscopy safely
 2. Presence of a pacemaker, internal defibrillator, or other implantable electronic devices
 3. Known hypersensitivity to drugs used during bronchoscopy such as lidocaine, midazolam, fentanyl
 4. Severe comorbid conditions that would increase the risk of adverse events during the procedure based on an assessment by the proceduralist.

ADDITIONAL INFORMATION

None

CLINICAL/REGULATORY RESOURCE

None

DEFINITION OF TERMS

None

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