Bronchial Thermoplasty (for Indiana Only)

Policy Number: CS014IN.02
Effective Date: September 1, 2021

Instructions for Use

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Related Policies
None

Application

This Medical Policy only applies to the state of Indiana.

Coverage Rationale

Bronchial thermoplasty is unproven and not medically necessary for treating asthma due to insufficient evidence of efficacy.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT 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

Description of Services

Asthma is a heterogeneous and chronic disease characterized by variable symptoms such as wheeze, shortness of breath, chest tightness and/or cough that vary over time and in intensity, together with variable expiratory airflow limitation (GINA 2021). Standard treatment approaches for asthma involve environmental control measures and avoidance of risk factors, plus

comprehensive drug therapy. Long-term control medications, such as inhaled corticosteroids or long-acting beta$_2$-agonists (LABA), long-acting muscarinic agents (LAMAs), leukotriene antagonists, and biologics may help reduce airway inflammation and prevent asthma symptoms. Quick-relief medications, such as short-acting beta$_2$-agonists, relieve asthma symptoms that may cause flare of symptoms. Adding an inhaled corticosteroid (ICS) controller to daily treatment is often recommend to control exacerbations and symptoms.

Bronchial thermoplasty (BT) is a procedure intended for treating adults with severe persistent asthma that is not well controlled with conventional drug therapy. BT is a minimally invasive, outpatient procedure that uses thermal energy (radiofrequency) to reduce smooth muscle mass which in turn, reduces airway constriction and may reduce the severity and frequency of asthma symptoms. The treatments are three outpatient visits over a three-week period. The BT procedure is performed using a standard flexible bronchoscope, which is introduced through the nose or mouth and into the lungs. The catheter tip has an expanded basket with four arms that contact the airway wall. A controlled thermal energy is then delivered to the airway walls to reduce excess smooth muscle tissue while leaving surrounding tissue undamaged. (ECRI, 2020)

Clinical Evidence

Bronchial thermoplasty (BT) is a non-drug procedure used to treat adult patients with severe asthma who remain symptomatic despite adherence to conventional treatments. Conclusive quality evidence is lacking to support the safety and efficacy of BT in the control of severe asthma and asthma exacerbation. Further randomized control studies are needed to determine the durability of clinical effects, assess long-term adverse events, and further understand the mechanism of BT on asthma.

Chaudhuri and colleagues (2021) conducted an international, multicenter prospective follow-up of three randomized control trials; the Asthma Intervention Research (AIR) trial, the Asthma Intervention Research-2 (AIR2) trial, and the Research in Severe Asthma (RISA) trial to determine safety and effectiveness outcomes of bronchial thermoplasty (BT) in patients with persistent asthma 10+ years (BT10+) after the procedure. The BT10+ study included 192 participants; 136 participants who received BT in the original trial, and 56 sham or control participants of which 18 received BT after the previous study ended The follow-up was 10·8–15·6 years (median 12·1 years) post-treatment. A reduction in hospital emergency department visits and hospital admissions for asthma were observed. Quality of life measurements and spirometry were similar between year 1, year 5, and the BT10+ visit. Reductions in both the proportion of participants with severe exacerbations after BT and the number of severe exacerbations per participant appeared to be sustained for 10 years or more The authors concluded the data from the BT10+ study showed efficacy and safety for those who underwent BT for 10+years. The authors noted several study limitations. The length of time between participation in original trials and the BT10+, resulted in several participants not being included in the BT10+ study. The study was funded by the manufacturer of the bronchial thermoplasty system and three of the authors are full-time employees of the manufacturer, which could potentially lead to a conflict of interest. Additionally, the study is limited by differential loss-to-follow-up between sham and active group and cross-over to the active group. Furthermore, the main findings on which the conclusion are made are based on the active group persistence of effect over time (case series design) rather than on a comparison with the sham group.

Langton et al. (2020) conducted a small prospective case series on the effect of bronchial thermoplasty (BT) 12 months post-procedure. The study included 10 patients with severe asthma who needed inhaled triple therapy and had poorly controlled symptoms with frequent exacerbations requiring oral steroids. Baseline data collected included an Asthma Control Questionnaire (ACQ), a high-resolution CT at total lung capacity (TLC), and a functional residual capacity (FRC). The ACQ score at baseline was 3.4±1.0 after left lung was treated 2.1±0.9, then six weeks after both lungs were treated 1.4±1.0 6 and 1.5±12 months post-procedure. The CT protocol was repeated four weeks after the left lung had been treated by BT, but prior to right lung treatment, and then again 12 months after both lungs were treated The TLC measured by CT scanning at baseline 4.91±1.55 L and at 12 months was 4.98±1.25 L. The FRC, the total lung volume at baseline was 3.63±1.12 L and at 12 months was 3.50±1.15 L. The authors concluded that BT induces long-term increases in airway volume, which correlate with symptomatic improvement, and the CT scan method at TLC is a promising tool for future objective evaluations of patient responses to BT. This study is limited by a lack of comparison group and small sample size.

An ECRI clinical evidence assessment report on the Alair™ Bronchial Thermoplasty System focused on how well Alair works for treating severe asthma patients unresponsive to medications. The assessment reviewed clinical studies published between January 1, 2008 to May 12, 2020, identified two systematic reviews and one nonrandomized comparison study reporting on a total of 1,845 patients. The assessment concluded that Alair's reported benefits are modest and of unclear clinical significance for asthma control, asthma exacerbation, reduced hospitalizations, and quality of life (QOL) up to one year, based on these

reviews. Adverse events (AEs) were more common with Alair than sham or standard medical therapy. The evidence was considered inconclusive and larger, multicenter RCTs that report longer-term outcomes are needed to validate BT with Alair. (ECRI, April 2007; updated May 2020) (Publications, including publications included in previous versions of this policy, by D'Anci et al. (2017) Niven et al. (2018), Zhou et al. (2016), Torrengo et al. (2014) and Wu (2011) are included in this review).

Goorsenberg and colleagues (2020) conducted an international-multicenter randomized control trial of 40 patients with severe asthma who underwent bronchial thermoplasty (BT) induced airway smooth muscle (ASM) reduction at enrollment or after a delay of six months. The aim was to assess the effects of BT on ASM mass in airways and to compare baseline and post BT. The outcomes were measured by Asthma Control Questionnaire (ACQ) and Asthma Quality of Life Questionnaire (AQLQ) results. Twenty patients received immediate BT treatment, and 20 (control group) received BT treatment 6 months later. Both groups underwent BT treatment of right lower lobe (RLL), left lower lobe (LLL) and then right upper lobe (RUL) and left upper lobe (LUL) within a three-week interval. The right middle lobe (RML) was not treated in all 40 patients. Patients underwent ASM biopsies prior to BT, during BT, from RML, and at six months post BT. Median ASM mass decreased by .50% in the immediate BT group versus no change in the control group (P = 0.0004). In the immediate group, Asthma Control Questionnaire scores improved with 20.79 (interquartile range [IQR], 21.61 to 0.02) compared with 0.09 (IQR, 20.25 to 1.17) in the delayed group (P = 0.006). AQLQ scores improved with 0.83 (IQR, 20.15 to 1.69) versus 20.02 (IQR, 20.77 to 0.75) (P = 0.04). The authors concluded BT significantly reduces ASM mass in patients with severe asthma compared to the patients in the control group. They also identified ASM mass in the proximal parts of the untreated RML were improved as well. The study is limited by lack of masking, which could have impacted prescription of additional therapies and responses to the subjective questionnaire, as well as a small sample size, which could have been insufficient to detect important adverse events. Furthermore, the comparison between randomized arms was limited to six months. Clinical trials.gov Identifier: NCT02225392.

Qiu er al. (2020) conducted a retrospective study to analyze the data for radiologic and bronchoscopic changes in 12 patients who had severe asthma and had undergone bronchial thermoplasty (BT). All 12 patients underwent a baseline chest X-ray or CT scan prior to the procedure. Within 24 hours of the procedures, a total of 9 patients had symptoms including cough, expectoration, tachypnea, wheezing, chest tightness, chest pain, and dyspnea. At 18-24 hours post BT, a total of 33 chest X-rays and one CT scan were collected. Radiological abnormalities were observed in 32 X-rays which included which included atelectasis (53.1%), peribronchial consolidations (84.4%), pleural effusion (18.8%), effusion in oblique fissures (3.1%), pleural thickening (6.3%) and pneumothorax (3.1%). At follow-up visits between 2-15 days after BT, a total of seven patients developed tachypnea, chest tightness, chest pain, wheezing, or dyspnea. At that time, 23 bronchoscopic examinations were required which revealed phlegm plugs occluding the bronchus in the treated lobe. At follow-up, 16-30 days post BT, 95.7% of the chest X-ray issues were resolved, and no bronchoscopies were required. The authors concluded from this study that this is the first case of pneumothorax post BT that needed intubation and there is high incidence for early radiologic abnormalities and bronchial phlegm plugs.

In the Hayes 2020 bronchial thermoplasty for treatment of asthma annual review 24 abstracts were retrieved, including one randomized controlled trial, one comparison of two prospective multicenter studies, one retrospective comparison study, one prospective uncontrolled study, 14 case series studies, four registry analysis, one systematic review, and one cost-effectiveness analysis. Evaluation of the literature indicated that evidence on patient selection criteria was unchanged. The review identified no new evidence with longer-term follow-up. The authors concluded that bronchial thermoplasty for severe, persistent asthma in adult patients (18 years or older) whose asthma has not been well controlled by long-acting bronchodilators and glucocorticoids did show some positive but inconsistent results regarding short-term benefits. A small, low-quality body of evidence was found and suggested that this technology has potential but unproven benefits (Hayes, 2020). Publications, including publications included in previous versions of this policy, by Seeley et al. (2019), Langton et al. (2018a), Langton et al. (2018b), Niven et al. (2018), Burn et al. (2017), Chupp et al. (2017) are included in this review.

A systematic review to assess the effectiveness and safety of BT in adults with asthma was conducted by D'Anci et al. (2017). Fifteen studies, including three randomized control trials (RCTs) with 5-year single-arm follow-up in BT-treated patients (n=432), examined the impact of BT in addition to standard care (continued medical management) on patients with asthma. Compared with standard care, BT improved asthma control, health care utilization (defined by rescue medication use), and quality of life (low strength of evidence [SOE]). The clinical relevance of these findings is uncertain. Rates of mild exacerbations were reduced following BT (low SOE), but the clinical relevance was uncertain. The evidence base was insufficient to draw conclusions about BT's effects on severe exacerbations, FEV1, and airway hyper-responsiveness compared with standard care. Compared with sham treatment, BT had no effect on asthma control, hospitalizations for respiratory symptoms, health care utilization, pulmonary physiology measures, or other asthma symptoms outcomes (low SOE). Reduced risk of severe

exacerbations was suggested (low SOE), although the clinical importance of this difference was unclear. BT was associated with fewer emergency department visits than sham treatment during the post-treatment period (moderate SOE). The evidence was inconclusive regarding quality of life scores following BT or sham (insufficient SOE). Serious adverse events attributed to BT were infrequent, and no deaths were reported. The authors concluded that based on the available literature, BT may be modestly beneficial in some patients with asthma but is not without risks. The risk of adverse events is higher early in treatment, while benefit is typically observed weeks to months after therapy and can last for at least 5 years, after which the effect is unknown.

Pretolani et al. (2017) examined the effect of BT on bronchial structures and explored the association with clinical outcome in patients with severe refractory asthma. Bronchial biopsy specimens (n = 300) were collected from 15 patients with severe uncontrolled asthma before and three months after BT. Immunostained sections were assessed for airway smooth muscle (ASM) area, subepithelial basement membrane thickness, nerve fibers, and epithelial neuroendocrine cells. Histopathologic findings were correlated with clinical parameters and were associated based on Asthma Control Test scores, numbers of exacerbations, and visits to the emergency department 3 and 12 months after BT. At 3 months, the clinical benefit noted was a reduction in ASM area (median values before and after BT, respectively: (19.7% and 5.3%), subepithelial basement membrane thickening (4.4 μm and 3.9 μm), submucosal nerves (1.0 ‰ immunoreactivity and 0.3 ‰ immunoreactivity), ASM-associated nerves (452.6 immunoreactive pixels per mm and 62.7 immunoreactive pixels per mm) and epithelial neuroendocrine cells (4.9/mm and 0.0/mm). Six of the 15 BT-treated patients with severe asthma still experienced uncontrolled asthma at 3 months and 4 at 12 months. The authors concluded that BT significantly improved asthma control and quality of life at both 3 and 12 months and decreased the numbers of severe exacerbations and the dose of oral corticosteroids. They further state that BT is a treatment option in patients with severe therapy-refractory asthma that downregulates selectively structural abnormalities involved in airway narrowing and bronchial reactivity, particularly ASM, neuroendocrine epithelial cells, and bronchial nerve endings. The study is limited by lack of comparison group and a small sample size.

Patients were recruited in the setting of a prospective clinical trial aimed at evaluating the effect of bronchial therapy (BT) in patients with severe therapy-uncontrolled asthma (Debray et al., 2017). Unenhanced chest CT was performed the day after each BT session in 13 patients with severe asthma, leading to the examination of 38 treated lobes. A total of 15 BT-treated lobes were evaluated in 11 patients at one month. Follow-up CT examinations were performed at one week in the first two patients to assess the evolution of opacities. No symptoms suggestive of pulmonary infection were noted following BT in any patient. Peribronchial consolidations were present on the day after BT in all treated lobes with three lower lobes showing complete collapse. Mild involvement of an adjacent untreated lobe was observed in 12 out of 38 (32%) cases. Opacities had decreased in 5 out of 15 (33%) and disappeared in 10 out of 15 (67%) at one month. Mild focal bronchial dilatations were noted a few months later in three treated lobes. The authors concluded that the mechanism and clinical significance of such dilatations deserve further evaluation. The limitations of the study include the lack of comparison group, the low number of patients with severe asthma examined, the lack of histologic correlation to explain the nature of pulmonary opacities, and the short duration of the follow-up.

A 2016 Hayes Medical Technology Assessment Directory Report of bronchial thermoplasty reviewed seven studies, including one good-quality randomized controlled trial (RCT), two fair-quality RCTs, one very-poor-quality retrospective cohort study, and three very-poor-quality case series. The report concluded that a small, low-quality body of evidence suggests that during the first year following treatment, BT may improve quality of life (QOL) outcomes. Some evidence also suggests symptom relief, reductions in emergency department visits, and reduced medication use; however, the results were inconsistent across studies. Hayes noted that BT did not reduce the rate of hospitalizations following treatment, and increased hospitalization during the treatment period. The report notes current evidence is insufficient to establish the long-term safety and efficacy of bronchial thermoplasty (Hayes, 2016).

Zhou et al. (2016) performed a systematic literature review of peer-reviewed studies (n=6) focusing on BT intervention in asthma control published between January 2000 and June 2014 to evaluate the long-term efficacy and safety of BT in the treatment of patients with moderate-to-severe persistent asthma. Two hundred and forty-nine subjects between the ages of18 and 65 years , diagnosed with moderate-to-severe persistent asthma, requiring daily therapy with inhaled corticosteroid (ICS) and who received BT procedures at least once using the Alair system were included in the studies. Outcomes assessed after BT included spirometric data, adverse respiratory events, emergency room (ER) visits and hospitalization for respiratory illness at a one year and five-year follow-up. No evidence of significant decline was found in pre-bronchodilator forced expiratory volume (FEV1), or in post-bronchodilator FEV1 between one year and five years. The most common side effects were airway irritation, including worsening asthma symptoms (wheezing, chest discomfort, cough, and chest pain), and upper respiratory tract

infections. The frequency of respiratory adverse events was reduced significantly during the follow-up. The number of ER visits for adverse respiratory events remained unchanged after BT treatment. There was no statistically significant increase in the incidence of hospitalization for respiratory adverse events. The authors concluded that BT shows reasonable long-term safety and efficacy for moderate-to-severe asthmatic patients. A large-scale clinical study should be performed for confirming the finding. There are several limitations in this study. Almost all studies included in this meta-analysis did not have a control group (sham group) for the 5-year follow-up. The authors state that findings from current studies are based merely on clinical manifestations and outcomes and that histological assessment after BT treatment could provide more evidence to support the findings.

A Cochrane systematic review by Torrego et al. (2014) concluded, based on the review of three trials (429 participants) that BT for patients with moderate to severe asthma provides a modest clinical benefit in quality of life and lower rates of asthma exacerbation, but no significant difference in asthma control scores. The quality of life findings was at risk of bias, as the main benefits were seen in the two studies that did not include a sham treatment arm. This procedure increases the risk of adverse events during treatment but has a reasonable safety profile after completion of the bronchoscopies. The overall quality of evidence regarding this procedure is moderate. For clinical practice, it would be advisable to collect data from patients systematically in independent clinical registries. Further research should provide better understanding of the mechanisms of action of bronchial thermoplasty, as well as its effect in different asthma phenotypes or in patients with worse lung function.

Patients enrolled in the Asthma Intervention Research (AIR) Trial were invited to participate in a 4-year safety study. Adverse events (AEs) and spirometry data were used to assess long-term safety out to five years post-bronchial thermoplasty (BT). A total of 45 of 52 treated and 24 of 49 control group subjects participated in long-term follow-up of five years and three years respectively. The rate of respiratory adverse events (AEs/subject) was stable in years two to five following BT. There was no increase in hospitalizations or emergency room visits for respiratory symptoms in years two, three, four, and five compared to year one, but the authors failed to detect significant group differences in hospitalizations or emergency room visits. The FVC and FEV1 values showed no deterioration over the five-year period in the BT group. Similar results were obtained for the control group. The absence of clinical complications and the maintenance of stable lung function over a five-year period post-BT in this group of patients with moderate to severe asthma support the long-term safety of the procedure out to five years. This study is limited by the nonblinded study design and the potential for bias due to manufacturer sponsorship and the findings are inconclusive on the benefit of BT compared to control (Thomson et al., 2011).

A meta-analysis by Wu et al. (2011) assessed the safety and efficacy of BT in patients with moderate to severe asthma. Compared with standard medications and sham treatment (combined), BT caused more adverse respiratory events and hospitalizations, but most events resolved within a week. While the two randomized controlled trials that did not include a sham procedure appeared to show some benefits on quality of life and peak flow, these findings were not significant for the sham-controlled trial. The authors concluded that additional long-term randomized controlled trials are needed to confirm whether BT provides benefit to patients with moderate to severe persistent asthma.

Clinical Practice Guidelines

American College of Allergy, Asthma and Immunology (ACAAI)

In a 2015 statement, the ACAAI states that “Bronchial thermoplasty is a well-studied treatment for patients with very severe asthma who continue to be symptomatic despite maximal medical treatment including steroids, long-acting beta agonists (LABAs), long-acting muscarinic agents (LAMAs), leukotriene antagonists and biologics. The scientific literature supports bronchial thermoplasty as a therapeutic consideration for some carefully chosen patients with severe asthma. Carefully selected patients with severe, persistent asthma who have persistent burden of disease, asthma exacerbations, emergency department visits or hospitalizations despite maximal medical treatment may benefit from this procedure.”

American College of Chest Physicians (CHEST)

In a 2014 document titled ‘Coverage and Payment for Bronchial Thermoplasty for Severe Persistent Asthma’, CHEST notes bronchial thermoplasty offers an important treatment option for adult patients with severe asthma who continue to be symptomatic despite maximal medical treatment and, therefore should not be considered experimental.

British Thoracic Society (BTS)

A BTS July 2019 guideline on the management of asthma states that bronchial thermoplasty may be considered for the treatment of adult patients who have poorly controlled asthma despite optimal therapy. Assessment and treatment for bronchial thermoplasty should be undertaken in centers that have expertise in the assessment of difficult to control asthma and in fiberoptic bronchoscopic procedures. The balance of risks and benefits of bronchial thermoplasty treatment should be discussed with patients being considered for the procedure. Longer term follow-up of treated patients is recommended. Further research is recommended into factors that identify patients who will or will not benefit from bronchial thermoplasty treatment (Grade A – highest rating).

European Respiratory Society/American Thoracic Society (ERS/ATS)

In a joint guideline on severe asthma, the ERS and the ATS recommend that bronchial thermoplasty is performed in adults with severe asthma only in the context of an Institutional Review Board-approved independent systematic registry or a clinical study (strong recommendation, very low quality evidence). The guidelines also include data regarding the increased risk of adverse events. Three studies on bronchial thermoplasty demonstrated increased risk of hospitalization (relative risk [RR]: 2.3, 95% confidence interval [CI]: 1.3–3.9). All studies reported adverse effects related to respiration only. Bronchial thermoplasty increased the risk of respiratory adverse effects in the initial treatment phase (relative risk [RR]: 1.13, 95% CI: 0.99–1.28 [number of patients with at least 1 adverse event]; rate ratio: 3.3, 95% CI: 2.4–4.5 [number of adverse events]), irrespective of their severity.

According to guideline authors, both the potential benefits and harms may be considerable, and the long-term consequences are unknown regarding this new approach to asthma therapy with an invasive physical intervention. Well-designed clinical studies are needed to define its effects on relevant objective health outcomes, such as exacerbation rates, and lung function, assessed over the long term. Studies are also needed to better understand the phenotypes of responding patients, the effect of the technology in patients with severe obstructive asthma (FEV_1 <60% of predicted value), and in patients being treated with systemic corticosteroids. Further research is likely to have an important impact on this recommendation (Chung et al., 2014).

Global Initiative for Asthma (GINA)

In 2021 GINA guidelines lists the following recommendations for bronchial thermoplasty:

- Adult patients who are managing severe asthma that remains uncontrolled despite optimal asthma therapy and after a referral to severe asthma specialty center, Bronchial thermoplasty may be considered as a treatment option for highly selected adults with severe asthma. But caution should be in used in patient selection as long-term effects and lung function are not known.
- Evidence is limited, smaller study groups and in selected patients their asthma treatment was not optimized prior to a Bronchial Thermoplasty (Evidence level B – limited body of data).

Large cohort studies are needed, longer-term follow-up and lung function comparing effectiveness and safety in both actively treated and sham-treated patients to identify its efficacy and long-term safety in broader severe asthma populations.

National Heart, Lung and Blood and Blood Institute (NHLBI)/ National Asthma Education and Prevention Program Coordinating Committee (NAEPPCC)

An Expert Panel Working group of NAEPPCC coordinated with NHLBI adopted these 2020 guidelines for Bronchial Thermoplasty (BT). Patients that are 18 years and older with uncontrolled, moderate-to-severe, persistent asthma should not undergo BT due to small patient benefit with moderate risk and long-term outcomes that are uncertain. This rationale is based on three randomized control studies with a total of 432 patients undergoing either treatment with high-dose fluctisone, long-acting beta agonists (LABA), with or without daily oral corticosteroids and omalizumab. The intervention group underwent either a sham bronchoscopy or BT. Both interventions patients received medicinal treatment in some combination as well. The expert panel concluded there is low certainty of evidence, and if patients do receive BT they should be enrolled in registries, ongoing clinical trials, or studies that can track long-term safety and effectiveness.

National Institute for Health and Care Excellence (NICE)

A 2018 NICE interventional procedures guidance on bronchial thermoplasty for severe asthma included evidence from two systematic reviews with meta-analysis, one randomized controlled trial, three case series (two of which were extensions of randomized trials; evidence from one was extracted from two published sources), one non-randomized comparative study, one

registry and five case reports. The committee found that there is uncertainty about which patients may benefit from the procedure and that BT should only be used for severe asthma that is not controlled despite optimal drug treatment. Further research should report details of patient selection and long-term safety and efficacy outcomes.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The Alair® Bronchial Thermoplasty System (Asthmatx, Inc.) received premarket approval on April 27, 2010 (P080032). Alair is indicated for the treatment of severe persistent asthma in patients 18 years and older whose asthma is not well controlled with inhaled corticosteroids and long acting beta agonists. Refer to the following website for more information (use product code OOY): https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm. (Accessed May 28, 2021)

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Policy History/Revision Information

Date	Summary of Changes
09/01/2021	Supporting Information • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect most current information • Archived previous policy version CS014IN.01

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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