Clinical Policy: Fractional Exhaled Nitric Oxide

Reference Number: CP.MP.103
Last Review Date: 11/19

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Fractional exhaled nitric oxide (FeNO) measurement is a noninvasive and simple test thought to reflect eosinophilic airway inflammation. While measurement of FeNO is standardized, there are currently no reference guidelines available to aid practitioners in appropriately applying test results in practice.

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that testing for fractionated exhaled nitric oxide (FeNO) is investigational for diagnosing and guiding the treatment of asthma, as there is insufficient evidence proving it more than or as effective as existing standards of care.

Background
There are multiple methods for diagnosing and assessing control of asthma and, according to the American Thoracic Society (ATS), no single test is an adequate indicator of asthma control.1 Conventional, objective methods to assess asthma include spirometry/peak flow and degree of airway hyper-responsiveness.2 These methods are often used as measures of asthma control in addition to patient symptoms, clinical questionnaires, and use of rescue medications.2,3 Newer methods of diagnosing and assessing control of asthma include the use of biomarkers of airway inflammation such as FeNO and induced sputum analysis.4

FeNO describes the levels of exhaled nitric oxide (NO) in the breath and NO is a mediator involved in lung inflammation that is largely formed in the lower airways.5 Increased levels of FeNO are associated with eosinophilic inflammation, severe asthma, and inhaled glucocorticoid-naïve asthma.4 Although there are some correlations between FeNO and characteristics related to asthma, there is large variability in FeNO levels between individuals. Other factors that may affect FeNO include atopy, sex, age, and cigarette smoking.3 However, there are no established guidelines for adjusting FeNO values according to these factors,3 potentially making the test less accurate for certain populations.

There are currently three types of FeNO tests approved by the FDA5 and there is a large body of literature on FeNO testing for the diagnosis and management of asthma. Overall, the evidence is mixed for using FeNO as an adjunct to the diagnosis or management of asthma. Multiple studies have shown that FeNO can serve as an indicator of glucocorticoid response.3,4,6 However, large studies, randomized control trials and a meta-review have found no clinical benefit to the use of FeNO testing over other methods of assessing or managing asthma.2,4,7-9

Among the studies that found a benefit to the use of FeNO testing,6,10-13 there was little agreement regarding FeNO cutoff values which would indicate asthma diagnosis or control.3,5 Although the ATS has recommended specific FeNO cutoff values to serve as guidelines for the
diagnosis and treatment of asthma, these standardized values have not been consistently used in
the research to date on FeNO testing. An additional drawback to FeNO testing for the
diagnosis or management of asthma is that it is most indicative of inflammation caused by
eosinophils, which characterizes only one subtype of asthma.

A 2016 Cochrane Review evaluating the use of FeNO in guiding treatment for adults with
asthma concluded that, while management guided by FeNO levels results in reduced
exacerbations, it cannot be advocated universally since it does not affect day-to-day clinical
symptoms, end-of-study FeNO levels, or inhaled corticosteroid dose. Furthermore, a systematic
review and meta-analysis evaluating the diagnostic accuracy of FeNO in asthmatic children
found that FeNO has only moderate diagnostic performance.

Given the equivocal results of research on the accuracy and usefulness of FeNO testing for the
diagnosis and management of asthma, the lack of standardized cutoff values, and the need for
further study, FeNO testing for the diagnosis and/or management of asthma is considered
experimental, investigational, or unproven.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered
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from the current manuals and those included herein are not intended to be all-inclusive and are
included for informational purposes only. Codes referenced in this clinical policy are for
informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.
Providers should reference the most up-to-date sources of professional coding guidance prior to
the submission of claims for reimbursement of covered services.

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<th>CPT® Codes</th>
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<tr>
<td>95012</td>
<td>Nitric Oxide expired gas determination</td>
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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

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Reviews, Revisions, and Approvals

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<th>Description</th>
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<tr>
<td>Policy created</td>
<td>12/15</td>
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<tr>
<td>Changed FeNO to investigational from not medically necessary. References</td>
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<td>reviewed and updated, along with background information.</td>
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References

Important reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at [http://www.cms.gov](http://www.cms.gov) for additional information.