

Medical Policy and InterQual® Criteria

Hyperbaric Oxygen Therapy (HBOT) or Topical Oxygen Therapy (TOT)

Policy Number: OCA 3.75

Version Number: 20

Version Effective Date: 12/01/21

Product Applicability		<input checked="" type="checkbox"/> All Plan⁺ Products
WellSense Health Plan		Boston Medical Center HealthNet Plan
<input checked="" type="checkbox"/> NH Medicaid		<input checked="" type="checkbox"/> MassHealth
<input checked="" type="checkbox"/> NH Medicare Advantage		<input checked="" type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct
		<input checked="" type="checkbox"/> Senior Care Options

⁺ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers outpatient, systemic hyperbaric oxygen therapy (HBOT) **medically necessary** for an adult or pediatric member when **InterQual® criteria** are met. The Plan considers the use of topical oxygen therapy (TOT) for the treatment of wounds to be **experimental and investigational or NOT medically necessary** due to limited evidence demonstrating the clinical utility and clinical validity of treatment. Prior authorization may or may not be required for HBOT based on the indication for treatment (including the member’s primary diagnosis code), the applicable procedure code used to accurately document and billing for treatment, and the location of care, as specified below:

1. Plan prior authorization is **REQUIRED** for outpatient, systemic HBOT when the member’s medical condition is **NOT** listed in the Applicable Coding section as a waived primary diagnosis code. **InterQual® criteria** must be met.

Hyperbaric Oxygen Therapy (HBOT) or Topical Oxygen Therapy (TOT)

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- Plan prior authorization is NOT required for outpatient, systemic HBOT when the member's medical condition is listed in the Applicable Coding section as a waived primary diagnosis code. **The waived, primary diagnosis code and procedure code must be accurately documented on the claim form using codes specified in the Applicable Coding section of this policy.** (The prior authorization waiver excludes the HCPCS codes considered experimental and investigational or NOT medically necessary, as stated in the Applicable Coding section).

Clinical Criteria

The Plan considers outpatient, systemic hyperbaric oxygen therapy (HBOT) medically necessary when InterQual® criteria are met. Review the prior authorization guidelines outlined in the Policy Summary section.

Limitations and Exclusions

The Plan considers the use of topical oxygen therapy (TOT) for the treatment of wounds to be experimental and investigational or NOT medically necessary for adult and pediatric members due to limited evidence demonstrating the clinical utility and clinical validity of treatment.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 2029 includes medically necessary indications for hyperbaric oxygen therapy. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS on the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

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Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitation and Exclusions section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member's benefit plan. Member benefit documents are available at the following websites; www.bmchp.org for BMC HealthNet Plan members, www.SeniorGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

ICD-10 Codes	Description: Prior authorization is NOT required for ANY of the following waived, primary diagnosis codes for outpatient, systemic hyperbaric oxygen therapy (HBOT) when the service is billed with a covered CPT and/or HCPCS code listed below for an adult or pediatric member.
A42.0-A42.9	Actinomycosis
A43.0-A43.9	Nocardiosis
A48.0	Gas gangrene
B47.1	Actinomycetoma
B47.9	Mycetoma, unspecified
H05.021-H05.029	Osteomyelitis of orbit
I74.2-I74.4	Embolism and thrombosis of arteries of extremities
M72.6	Necrotizing fasciitis
M86.30-M86.39	Chronic multifocal osteomyelitis
M86.40-M86.49	Chronic osteomyelitis with draining sinus
M86.50-M86.59	Other chronic hematogenous osteomyelitis
M86.60-M86.69	Other chronic osteomyelitis
T20.20xA-T20.29xD	Burn of second degree of head, face, and neck, initial or subsequent encounter only
T20.30xA-T20.39xD	Burn of third degree of head, face, and neck, initial or subsequent encounter only
T20.60xA-T20.69xD	Corrosion of second degree of head, face, and neck, initial or subsequent encounter only
T20.70xA-T20.79xD	Corrosion of third degree of head, face, and neck, initial or subsequent encounter only
T21.20xA-T21.29xD	Burn of second degree of trunk, initial or subsequent encounter only
T21.30xA-T21.39xD	Burn of third degree of trunk, initial or subsequent encounter only
T21.60xA-T21.69xD	Corrosion of second degree of trunk, initial or subsequent encounter only
T21.70xA-T21.79xD	Corrosion of third degree of trunk, initial or subsequent encounter only

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T22.20xA- T22.29xD	Burn of second degree of shoulder and upper limb, excluding wrist and hand, initial or subsequent encounter only
T22.30xA- T22.399D	Burn of third degree of shoulder and upper limb, excluding wrist and hand, initial or subsequent encounter only
T22.60xA- T22.69xD	Corrosion of second degree of shoulder and upper limb, excluding wrist and hand, initial or subsequent encounter only
T22.70xA- T22.799D	Corrosion of third degree of shoulder and upper limb, excluding wrist and hand, initial or subsequent encounter only
T23.201A- T23.299D	Burn of second degree of wrist and hand, initial or subsequent encounter only
T23.301A- T23.399D	Burn of third degree of wrist and hand, initial or subsequent encounter only
T23.601A- T23.699D	Corrosion of second degree of wrist and hand, initial or subsequent encounter only
T23.701A- T23.799D	Corrosion of third degree of wrist and hand, initial or subsequent encounter only
T24.201A- T24.299D	Burn of second degree of lower limb, except ankle and foot, initial or subsequent encounter only
T24.301A- T24.399D	Burn of third degree of lower limb, except ankle and foot, initial or subsequent encounter only
T24.601A- T24.699D	Corrosion of second degree of lower limb, except ankle and foot, initial or subsequent encounter only
T24.701A- T24.799D	Corrosion of third degree of lower limb, except ankle and foot, initial or subsequent encounter only
T25.211A- T25.299D	Burn of second degree of ankle and foot, initial or subsequent encounter only
T25.311A- T25.399D	Burn of third degree of ankle and foot, initial or subsequent encounter only
T25.611A- T25.699D	Corrosion of second degree of ankle and foot, initial or subsequent encounter only
T25.711A- T25.799D	Corrosion of third degree of ankle and foot, initial or subsequent encounter only
T26.00xA- T26.42xD	Burn of eye and adnexa, initial or subsequent encounters only
T26.50xA- T26.92xD	Corrosion of eye and adnexa, initial or subsequent encounters only
T31.10-T31.99	Burns involving 0-99% of body surface with third degree burns
T32.10-T32.99	Corrosions involving 0-99% of body surface with third degree burns
T57.3X1A- T57.3X4D	Toxic effect of hydrogen cyanide, accidental (unintentional), initial or subsequent encounters only
T58.01xA-	Toxic effect of carbon monoxide, initial or subsequent encounters only

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T58.94xD	
T65.0X1A- T65.0X4D	Toxic effect of cyanides, initial or subsequent encounters only
T66.xxxA-T66.xxxD	Radiation sickness, initial or subsequent encounters only
T70.3xxA- T70.3xxD	Caisson disease [decompression sickness], initial or subsequent encounters only
T79.0xxA- T79.0xxD	Air embolism (traumatic), initial or subsequent encounters only
T80.0xxA- T80.0xxD	Air embolism following infusion, transfusion and therapeutic injection, initial or subsequent encounters only
T86.821	Skin graft (allograft) (autograft) failure
T86.822	Skin graft (allograft) (autograft) infection

CPT Code	Description: Code covered for outpatient, systemic HBOT when medically necessary.
99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session Plan note: This code should only be used for the professional component of outpatient, systemic HBOT.

HCPCS Code	Description: Code covered when medically necessary.
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval Plan note: This code should only be used for the technical component of outpatient, systemic HBOT.

HCPCS Codes	Description: Codes considered experimental and investigational or NOT medically necessary.
A4575	Topical hyperbaric oxygen chamber, disposable
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Originally Approved by
Regulatory Approval: N/A Internal Approval: 09/11/07: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 09/25/07: Utilization Management Committee (UMC) 10/15/07: Quality Improvement Committee (QIC)	04/01/08 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC, UMC, and QIC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12

*Effective Date for the WellSense New Hampshire Medicaid Product: 07/01/17

*Effective Date for the Senior Care Options Product: 01/01/16

*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy title 04/01/18 to 01/31/19 was *Hyperbaric Oxygen Therapy (HBOT) in the Outpatient Setting*. As of 02/01/19, the policy title has been changed to *Hyperbaric Oxygen Therapy (HBOT) or Topical Oxygen Therapy (TOT)*.

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
09/09/08	Clinical criteria changed for non-emergent conditions and preauthorization is required for non-emergent conditions effective 02/01/09.	Version 2	09/09/08: MPCTAC 10/28/08: UMC 11/18/08: QIC
10/27/09	Updated references, no changes to the clinical criteria.	Version 3	10/27/09: MPCTAC 11/19/09: QIC
09/01/10	Updated references.	Version 4	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	Clinical criteria was updated with additional treatment guidelines for compromised skin grafts, chronic, severe diabetic lower extremity wounds and osteoradionecrosis and a definition	Version 5	10/19/11: MPCTAC 11/29/11: QIC

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Policy Revisions History

	for standard wound care was added, updated references and coding.		
08/01/12	Off cycle review for WellSense New Hampshire Product, updated title to reference “outpatient”, revised Summary statement, revised Description of Item or Service, reformatted Medical Policy Statement, eliminating references to inpatient services and adding reference to outpatient services following inpatient services, revised Applicable Coding introductory statement, reformatted Limitations.	Version 6	08/17/12: MPCTAC 09/06/12: QIC
10/01/12 and 11/01/12	Revised Summary, Description of Item or Service, and Clinical Background Information sections. Reformatted Clinical Guideline Statement section. Revised Applicable Coding introductory statement and added diagnosis codes that do not require prior authorization. Revised and added to Limitations section. Revised title and text so policy applies to HBOT rendered in an outpatient setting only.	Version 7	10/17/12: MPCTAC 11/14/12: MPCTAC 12/20/12: QIC
01/01/13	Review for effective date 04/01/13. References updated and changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”	04/01/13 Version 8	01/16/13: MPCTAC 02/21/13: QIC
08/14/13 and 08/15/13	Off cycle review for WellSense New Hampshire Product and merged policy format. Incorporate policy revisions dated 10/01/12, 11/01/12, and 01/01/13 (as specified above) for the WellSense New Hampshire Product; these policy revisions were approved by MPCTAC (on 10/17/12, 11/14/12, and 01/16/13) and QIC (on 12/20/12 and 02/21/13) for applicable Plan products.	Version 9	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
02/01/14	Review for effective date 07/01/14. Revised notes in the tables included in the Applicable Coding section, updated code definitions, revised list of ICD9 diagnosis codes that have the prior authorization requirement waived. Updated Summary section and References section. Revised Medical Policy Statement section without changing criteria. Added ICD10 equivalent codes for ICD9 diagnosis codes included in policy.	07/01/14 Version 10	02/19/14: MPCTAC 03/26/14: QIC
07/01/14	Review for effective date 10/01/14. Changed ICD9 code range for burns of multiple specified	10/01/14 Version 11	07/21/14: MPCTAC (electronic vote)

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Policy Revisions History

	sites from 946.30-946.59 to 946.0-946.5 to include all codes in that diagnosis category. Added Plan notes to Applicable Coding section.		07/24/14: QIC (electronic vote)
01/01/15	Review for effective date 05/01/15. Updated Description of Item or Service, Definitions, and References sections. Updated applicable code list and updated Medical Policy Statement section to be consistent with Applicable Coding section.	05/01/15 Version 12	01/21/15: MPCTAC 02/11/15: QIC
10/01/15	Review for effective date 12/01/15. Updated template with list of applicable products and corresponding notes.	12/01/15 Version 13	10/21/15: MPCTAC 11/11/15: QIC
10/21/15 and 11/25/15	Review for effective date 02/01/16. Updated language in the Applicable coding section and changed HCPCS code G0277 from an experimental and investigational code to a medically necessary code for the technical component of the service (with a Plan note). Updated references. Revised criteria in the Medical Policy Statement and Limitations sections.	02/01/16 Version 14	10/21/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 11/11/15: QIC 12/09/15: QIC
11/01/16	Review for effective date 01/01/17. Removed ICD-9 diagnosis codes in the Applicable Coding section (according to industry standard) with no additional change to the applicable code list. Administrative changes made to the Summary, Medical Policy Statement, Limitations, Clinical Background Information, References, and References to Applicable Laws and Regulations sections. No change to criteria.	01/01/17 Version 15	11/16/16: MPCTAC 12/14/16: QIC
11/01/17	Review for effective date 02/01/18. Updated Description of Item or Service, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Administrative changes made to the Plan notes in the Applicable Coding section. Revised criteria in the Medical Policy Statement and Limitations sections.	02/01/18 Version 16	11/20/17: MPCTAC (electronic vote)
11/01/18	Review for effective date 03/01/19. Medical policy criteria retired and applicable InterQual® criteria adopted for outpatient HBOT. Revised the policy title and the Medical Policy Statement and Limitations sections. Administrative changes made to the Policy Summary, Applicable Coding,	03/01/19 Version 17	11/26/18: MPCTAC (electronic vote)

Hyperbaric Oxygen Therapy (HBOT) or Topical Oxygen Therapy (TOT)

* Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense New Hampshire Health Plan.

Policy Revisions History

	Clinical Background Information, References and Other Applicable Policies sections. Revised list of diagnosis codes waived for prior authorization and the description of waived diagnoses listed in the Policy Summary section.		
11/01/19	Review for effective date 12/01/19. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	12/01/19 Version 18	11/20/19: MPCTAC
11/01/20	Review for effective date 12/01/20. Updated the References section.	12/01/20 Version 19	11/18/20: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitation and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/21. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 20	11/17/21: MPCTAC

Next Review Date

11/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: *

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

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The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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