Medical Policy

Hyperbaric Oxygen Therapy (HBOT) in the Outpatient Setting

Policy Number: OCA 3.75
Version Number: 15
Version Effective Date: 01/01/17

Product Applicability

<table>
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<th>All Plan Products</th>
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<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
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<td></td>
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</tr>
</tbody>
</table>

Notes:
* Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers systemic hyperbaric oxygen therapy (HBOT) for specified conditions to be medically necessary when Plan criteria are met. Prior authorization may or may not be required based on the medical record documentation of the member’s indication for treatment and the type of service provided to the member (including the member’s primary diagnosis code, HBOT services provided to the member, applicable procedure code used when documenting and billing for treatment, and location of care), as specified below in items 1 through 3.
1. When systemic HBOT is provided in an outpatient setting, some medical conditions (i.e., indications for treatment) do REQUIRE Plan prior authorization, as specified in item A of the Medical Policy Statement section of this policy.

2. Other medical conditions may NOT require Plan prior authorization for systemic HBOT provided in the outpatient setting when Plan billing guidelines are met and medical record documentation supports that ALL of the following criteria are met, as specified in items a through c:
   a. Plan medical criteria in item B of the Medical Policy Statement section are met; AND
   b. Systemic HBOT is provided in an outpatient setting to a member who has a primary diagnosis that the Plan has waived a prior authorization requirement (by diagnosis) for this treatment, as stated in the Applicable Coding section of this policy (and this primary diagnosis code is also used for billing for HBOT); AND
   c. The medically necessary treatment is consistent with an applicable procedure code for systemic HBOT, as specified in the Applicable Coding section of this policy (and this procedure code is also used for billing for systemic HBOT).

3. An additional Plan prior authorization is NOT required for systemic HBOT provided in an inpatient setting when the inpatient admission has already been authorized by the Plan.

It will be determined during the Plan’s prior authorization process if the service is considered experimental and investigational for the requested use or if the service is considered medically necessary. See Plan policy, *Experimental and Investigational Treatment* (policy number OCA 3.12), for the product-specific definitions of experimental or investigational treatment. See Plan policy, *Medically Necessary* (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment.

**Description of Item or Service**

**Systemic Hyperbaric Oxygen Therapy (HBOT):** The medical use of oxygen administered in a single or multiple person chamber where the patient breathes 100% oxygen that is pressurized at 1.4-3.0 atmospheres absolute (atm abs). The goal of treatment is to increase oxygen levels in the patient’s systemic circulation. During HBOT, patients breathe pure oxygen gas at a pressure that is typically 2 to 3 times greater than the atmospheric pressure. The elevated concentration and pressure of the oxygen allows higher levels of oxygen absorption by the blood, creating hyperoxygenation in the tissues. HBOT may be used in certain emergent situations or in the treatment of certain chronic conditions.
Medical Policy Statement

The Plan considers systemic HBOT to be medically necessary as a treatment for the conditions specified below when Plan criteria are met. Plan prior authorization is not required when HBOT is provided in an inpatient setting. Some conditions require Plan prior authorization (as described below in item A) when HBOT is rendered in an outpatient setting, while other conditions do not require Plan prior authorization when HBOT is provided in an outpatient setting (as specified below in item B of this Medical Policy Statement section and in the Applicable Coding section of this policy):

A. Conditions That Require Plan Prior Authorization for Outpatient HBOT:

The Plan considers outpatient, systemic HBOT medically necessary WITH prior authorization when ALL of the following Plan criteria are met, as specified below in items 1 through 4:

1. A treatment plan, including the goal of the therapy and proposed number of treatments, has been submitted to the Plan for review; AND

2. The treatment is evaluated at least every 15 treatments and/or at least every 30 days during administration of HBOT, and the reevaluation shows continued progress/healing with treatment; AND

3. The member is age 18 or older on the date of service; ¥ AND

¥ Note: Plan Medical Director review is required for approval of HBOT administered on a member under the age of 18 on the date of service.

4. The member has at least ONE (1) of the following conditions, as specified below in items a through c:

a. Active osteoradionecrosis when a documented course of treatment or letter of medical necessity is submitted with the prior authorization request; OR

b. Compromised skin graft or flap when BOTH of the following criteria are met, as specified below in item (1) and item (2):

   (1) The treatment is used as adjunctive therapy (i.e., not for the primary management of wounds) only when there has been no measurable improvement in the member’s condition after 30 days of standard therapy; AND

   (2) Standard wound care includes ALL of the following, as specified below items (a) through (g):

   (g)
(a) Assessment of a patient's vascular status and correction of any vascular problems in the affected limb; AND

(b) Debridement by any means to remove devitalized tissue; AND

(c) Efforts of appropriate off-loading, AND

(d) Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; AND

(e) Necessary treatment to resolve any infection that might be present; AND

(f) Optimization of nutritional status; AND

(g) Optimization of glucose control;

OR

c. Chronic, severe, or gangrenous diabetic lower extremity wound when BOTH of the following criteria are met, as specified below in item (1) and item (2):

≈Note: When Plan criteria for HBOT are met for a chronic, severe, or gangrenous diabetic lower extremity wound, the Plan will grant an initial authorization of 15 treatments.

(1) The treatment is used as adjunctive therapy only when there has been no measurable improvement in the member’s condition after 30 days of standard therapy; AND

(2) Standard wound care includes ALL of the following, as specified below in items (a) through (g):

(a) Assessment of a patient's vascular status and correction of any vascular problems in the affected limb; AND

(b) Debridement by any means to remove devitalized tissue; AND

(c) Efforts of appropriate off-loading, AND

(d) Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; AND

(e) Necessary treatment to resolve any infection that might be present; AND
(f) Optimization of nutritional status; AND

(g) Optimization of glucose control.

B. **Conditions with No Prior Authorization Requirement for Outpatient HBOT:**

The Plan considers systemic HBOT medically necessary as a treatment for at least ONE (1) of the following conditions WITHOUT prior authorization when the member’s primary diagnosis code is listed in the Applicable Coding section of this Plan policy (and the waived, primary diagnosis code is listed on the claim form with the covered procedure code), as specified below in items 1 through 12:

1. Actinomycosis (i.e., chronic bacterial infection that causes inflammation, and formation of multiple abscesses and sinus tracts commonly found in the cervicofacial, thoracic, and abdominal areas), as an adjunct to conventional therapy when the disease is refractory to antibiotics and surgical treatment; OR

2. Acute carbon monoxide poisoning; OR

3. Acute thermal burn; OR

4. Acute peripheral arterial insufficiency; OR

5. Acute traumatic peripheral ischemia, crush injuries, and suturing of severed limbs as an adjunctive treatment to standard therapeutic measures when a loss of function, limb, or life is threatened; OR

6. Air or gas embolism; OR

7. Cyanide poisoning; OR

8. Decompression illness; OR

9. Gas gangrene (i.e., clostridial myositis or myonecrosis); OR

10. Progressive necrotizing infections (e.g., necrotizing fasciitis); OR

11. Refractory osteomyelitis; OR

Limitations

A. Plan Medical Director review is required for approval of systemic HBOT administered to a member under the age of 18 on the date of service.

B. Plan Medical Director review is required for approval of systemic HBOT administered to a member when applicable criteria in the Medical Policy Statement section of this policy are NOT met.

C. Relative contraindication to HBOT includes ANY of the following conditions, as specified below in items 1 through 8:

1. Active cancer (which is defined as a member in active treatment for cancer with chemotherapy and/or radiation, positive image scan of active cancer, or no evidence of remission); OR

2. Active untreated seizures; OR

3. Claustrophobia; OR

4. Fever; OR

5. Previous ear surgery or trauma; OR

6. Severe lung disease; OR

7. Significant upper respiratory infections; OR

8. Untreated pneumothorax

D. HBOT should not be used on Plan members with external medical devices or internal medical devices unless the device is FDA approved and also approved by the manufacturer for use with high pressure oxygen.

E. The use of erectile dysfunction medications should be discontinued at least 48 hours prior to the administration of HBOT.

F. Continued systemic HBOT is only considered medically necessary when measurable signs of healing have been demonstrated following the initial 15-session treatment period or within any 30-day treatment period (with medically necessary defined in the Plan policy, Medically Necessary, policy number OCA 3.14).
G. Topical HBOT is considered experimental and investigational (with experimental and investigational treatment defined in the Plan policy, Experimental and Investigational Treatment, policy number OCA: 3.12).

H. Systemic HBOT for ANY of the following conditions is considered experimental and investigational, as specified below in items 1 through 26 (with experimental and investigational treatment defined in the Plan policy, Experimental and Investigational Treatment, policy number OCA 3.12):

1. Acute cerebral edema; OR
2. Acute or chronic cerebral vascular insufficiency; OR
3. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency; OR
4. Aerobic septicemia; OR
5. Anaerobic septicemia and infection other than clostridial; OR
6. Arthritic disease; OR
7. Autism; OR
8. Brain injury; OR
9. Cardiogenic shock; OR
10. Cerebral palsy; OR
11. Chronic peripheral vascular insufficiency; OR
12. Cutaneous, decubitus, and stasis ulcers; OR
13. Exceptional blood loss anemia; OR
14. Headaches including migraine or cluster; OR
15. Hepatic necrosis; OR
16. Multiple sclerosis; OR
17. Myocardial infarction; OR
18. Nonvascular causes of chronic brain syndrome (e.g., Pick’s disease, Alzheimer’s disease, and Korsakoff’s disease); OR

19. Organ storage; OR

20. Organ transplantation; OR

21. Pulmonary emphysema; OR

22. Senility; OR

23. Sickle cell anemia; OR

24. Stroke; OR

25. Systemic aerobic infection; OR

26. Tetanus

**Definitions**

**Exceptional Blood Loss Anemia:** Loss of enough red blood cells to compromise sufficient oxygen delivery to the tissues in patients who cannot be transfused for medical or religious reasons. Medical reasons may include the threat of blood product incompatibility or concern for transmissible disease. Religious beliefs may prohibit the receipt of transfused blood products.

**Severe Anemia:** Anemia may be mild, moderate, or severe in nature according to the following general guidelines. Mild anemia, hemoglobin 9.5-11 g/dl, is often asymptomatic and frequently escapes detection. Moderate anemia, hemoglobin 8-9.5 g/dl, may present with other symptoms and warrants timely management to prevent long-term complications. Severe anemia, hemoglobin < 8 g/dl, will warrant investigation and prompt management. Dependent upon its etiology and the magnitude of the red blood cell (RBC) deficit, it may be life threatening.

**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). Because 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

Hyperbaric Oxygen Therapy (HBOT) in the Outpatient Setting

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Informati

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.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation 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. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines. Review the Plan’s applicable reimbursement policies, including Reimbursement Guidelines - General Clinical Editing and Payment Accuracy Review Guidelines, available at www.bmchp.org for BMC HealthNet Plan members and at www.wellsens.org for Well Sense Health Plan members.

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description: No prior authorization is required for the following waived, primary diagnosis codes for systemic HBOT for a procedure code covered by the Plan when medically necessary, as specified below. (The waived, primary diagnosis code must be documented on the claim form with the covered procedure code.)</th>
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<tbody>
<tr>
<td>A42.0-A42.9</td>
<td>Actinomycosis</td>
</tr>
<tr>
<td>A43.0-A43.9</td>
<td>Nocardiosis</td>
</tr>
<tr>
<td>A48.0</td>
<td>Gas gangrene</td>
</tr>
<tr>
<td>B47.1</td>
<td>Actinomycetoma</td>
</tr>
<tr>
<td>B47.9</td>
<td>Mycetoma, unspecified</td>
</tr>
<tr>
<td>H05.021-H05.029</td>
<td>Osteomyelitis of orbit</td>
</tr>
<tr>
<td>M72.6</td>
<td>Necrotizing fasciitis</td>
</tr>
<tr>
<td>M86.30-M86.39</td>
<td>Chronic multifocal osteomyelitis</td>
</tr>
<tr>
<td>M86.40-M86.49</td>
<td>Chronic osteomyelitis with draining sinus</td>
</tr>
<tr>
<td>M86.50-M86.59</td>
<td>Other chronic hematogenous osteomyelitis</td>
</tr>
<tr>
<td>M86.60-M86.69</td>
<td>Other chronic osteomyelitis</td>
</tr>
<tr>
<td>T20.30xA-T20.39xD</td>
<td>Burn of third degree of head, face, and neck, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T20.70xA-T20.79xD</td>
<td>Corrosion of third degree of head, face, and neck, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T21.30xA-T21.39xD</td>
<td>Burn of third degree of trunk, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T21.70xA-T21.79xD</td>
<td>Corrosion of third degree of trunk, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T22.30xA-T22.39xD</td>
<td>Burn of third degree of shoulder and upper limb, excluding wrist and hand,</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description: Code covered when medically necessary if Plan criteria are met or the service is billed with a waived, primary diagnosis code specified above.</td>
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<tr>
<td>99183</td>
<td>Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session</td>
</tr>
<tr>
<td></td>
<td>Plan note: This code should only be used for the professional component of the service.</td>
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<thead>
<tr>
<th>T22.399D</th>
<th>initial or subsequent encounter only</th>
</tr>
</thead>
<tbody>
<tr>
<td>T22.70xA-T22.799D</td>
<td>Corrosion of third degree of shoulder and upper limb, excluding wrist and hand, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T23.301A-T23.399D</td>
<td>Burn of third degree of wrist and hand, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T23.701A-T23.799D</td>
<td>Corrosion of third degree of wrist and hand, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T24.301A-T24.399D</td>
<td>Burn of third degree of lower limb, except ankle and foot, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T24.701A-T24.799D</td>
<td>Corrosion of third degree of lower limb, except ankle and foot, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T25.311A-T25.399D</td>
<td>Burn of third degree of ankle and foot, initial or subsequent encounter only</td>
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<tr>
<td>T25.711A-T25.799D</td>
<td>Corrosion of third degree of ankle and foot, initial or subsequent encounter only</td>
</tr>
<tr>
<td>T26.00xA-T26.42xD</td>
<td>Burn of eye and adnexa, initial or subsequent encounters only</td>
</tr>
<tr>
<td>T26.50xA-T26.92xD</td>
<td>Corrosion of eye and adnexa, initial or subsequent encounters only</td>
</tr>
<tr>
<td>T31.10-T31.99</td>
<td>Burns involving 0-99% of body surface with third degree burns</td>
</tr>
<tr>
<td>T32.10-T32.99</td>
<td>Corrosions involving 0-99% of body surface with third degree burns</td>
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<tr>
<td>T57.3X1A-T57.3X4D</td>
<td>Toxic effect of hydrogen cyanide, accidental (unintentional), initial or subsequent encounters only</td>
</tr>
<tr>
<td>T58.01xA-T58.94xD</td>
<td>Toxic effect of carbon monoxide, initial or subsequent encounters only</td>
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<tr>
<td>T65.0X1A-T65.0X4D</td>
<td>Toxic effect of cyanides, initial or subsequent encounters only</td>
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<td>T66.xxxA-T66.xxxD</td>
<td>Radiation sickness, initial or subsequent encounters only</td>
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<tr>
<td>T70.xxxA-T70.3xxD</td>
<td>Caisson disease [decompression sickness], initial or subsequent encounters only</td>
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<td>T79.0xxA-T79.0xxD</td>
<td>Air embolism (traumatic), initial or subsequent encounters only</td>
</tr>
<tr>
<td>T80.0xxA-T80.0xxD</td>
<td>Air embolism following infusion, transfusion and therapeutic injection, initial or subsequent encounters only</td>
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</table>
Hyperbaric Oxygen Therapy (HBOT) in the Outpatient Setting

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description: Code covered when medically necessary if Plan criteria are met or the service is billed with a waived, primary diagnosis code specified above.</th>
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<tbody>
<tr>
<td>G0277</td>
<td>Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval</td>
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<tr>
<td></td>
<td>Plan note: This code should only be used for the technical component of the service.</td>
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<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description: Codes considered experimental and investigational.</th>
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<tbody>
<tr>
<td>A4575</td>
<td>Topical hyperbaric oxygen chamber, disposable</td>
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<tr>
<td></td>
<td>Plan note: This service is NOT considered medically necessary for any diagnosis.</td>
</tr>
<tr>
<td>E0446</td>
<td>Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories</td>
</tr>
<tr>
<td></td>
<td>Plan note: This service is NOT considered medically necessary for any diagnosis.</td>
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Clinical Background Information

Hyperbaric oxygen therapy (HBOT) causes both mechanical and physiologic effects by inducing a state of increased pressure and hyperoxia. While the duration of an HBOT session is typically 90 to 120 minutes, the duration, frequency, and number of sessions have not been standardized. HBOT is administered in two (2) primary ways, using a monoplace (single-person) chamber or a multiplace chamber. A single-person chamber consists of a clear plastic tube about seven feet long. The patient lies on a padded table that slides into the tube and the chamber is gradually pressurized with pure oxygen. Multiplace chambers allow the treatment of several people (up to about 12) while medical personnel work inside the chamber. The entire multiplace chamber is pressurized, so medical personnel may require a controlled decompression, depending on how long they were exposed to the hyperbaric air environment.

HBOT is used as adjunctive treatment for conditions that include actinomycosis, osteomyelitis, osteoradionecrosis, peripheral ischemia, and radionecrosis. In general, the use of HBOT as an adjunctive therapy is medically necessary only after there are no measurable signs of healing for at least 30 days following standard medical and/or surgical treatment.

Side effects of HBOT are usually caused by changes in pressure within the chamber and can include middle ear effusion, tympanic membrane rupture, and pneumothorax. More severe complications are rare but oxygen toxicity, hypoglycemia, and severe nervous system disorders have been reported.

At the time of the Plan’s most recent policy review, the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) 20.29 includes the following clinical guidelines for coverage of hyperbaric oxygen therapy (HBOT) for Medicare beneficiaries as a modality in which the entire body is exposed to oxygen administered in a chamber under increased atmospheric pressure (including the one-person unit) for the following conditions: “(1) Acute carbon monoxide intoxication;

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(2) decompression illness; (3) gas embolism; (4) gas gangrene; (5) acute traumatic peripheral ischemia - HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened; (6) crush injuries and suturing of severed limbs - as in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened; (7) progressive necrotizing infections (necrotizing fasciitis); (8) acute peripheral arterial insufficiency; (9) preparation and preservation of compromised skin grafts (not for primary management of wounds); (10) chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management; (11) osteoradionecrosis as an adjunct to conventional treatment; (12) soft tissue radionecrosis as an adjunct to conventional treatment; (13) cyanide poisoning; (14) actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; or (15) diabetic wounds of the lower extremities in patients who meet the following three criteria: Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes; patient has a wound classified as Wagner grade III or higher; and patient has failed an adequate course of standard wound therapy.

According to NCD 20.29, “the use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in patients with diabetic wounds includes: assessment of a patient’s vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.” Verify CMS criteria in the applicable NCD, local coverage determination (LCD), and/or coverage guidelines in in effect on the date of the prior authorization request for HBOT for a Senior Care Options member.

References


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Centers for Medicare & Medical Services (CMS). National Coverage Analysis (NCA) for Hyperbaric Oxygen Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N). Accessed at: https://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId=37&Cov erageSelection=Both&ArticleType=All&PolicyType=Final&s=Massachusetts&KeyWord=hyperbaric&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAACAAAAAAA%3d%3d&

Centers for Medicare & Medical Services (CMS). National Coverage Analysis (NCA) for Hyperbaric Oxygen (HBO) Therapy (Section C, Topical Oxygen) (CAG-00060R). Accessed at: https://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId=286&Cov erageSelection=Both&ArticleType=All&PolicyType=Final&s=Massachusetts&KeyWord=hyperbaric&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAACAAAAAAA%3d%3d&


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<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
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<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td></td>
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</tr>
<tr>
<td>Internal Approval: 09/11/07: MPCTAC 09/25/07: UMC 10/15/07: QIC</td>
<td>04/01/08 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC, Utilization Management Committee (UMC), and QIC</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Heath Plan New Hampshire Medicaid Product(s): 01/01/13
*Effective Date for the Senior Care Options Product(s): 01/01/16

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
</tr>
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<tbody>
<tr>
<td>09/09/08</td>
<td>Clinical criteria changed for non-emergent conditions and preauthorization is required for non-emergent conditions effective 02/01/09.</td>
<td>Version 2</td>
<td>09/09/08: MPCTAC 10/28/08: UMC 11/18/08: QIC</td>
</tr>
<tr>
<td>10/27/09</td>
<td>Updated references, no changes to the clinical criteria.</td>
<td>Version 3</td>
<td>10/27/09: MPCTAC 11/19/09: QIC</td>
</tr>
<tr>
<td>09/01/10</td>
<td>Updated references.</td>
<td>Version 4</td>
<td>10/20/10: MPCTAC 11/22/10: QIC</td>
</tr>
<tr>
<td>10/01/11</td>
<td>Clinical criteria was updated with additional treatment guidelines for compromised skin</td>
<td>Version 5</td>
<td>10/19/11: MPCTAC 11/29/11: QIC</td>
</tr>
</tbody>
</table>

Hyperbaric Oxygen Therapy (HBOT) in the Outpatient Setting

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<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Version</th>
<th>Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/01/12</td>
<td>Off cycle review for Well Sense Health Plan, 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.</td>
<td>Version 6</td>
<td>08/17/12: MPCTAC 09/06/12: QIC</td>
</tr>
<tr>
<td>10/01/12 and 11/01/12</td>
<td>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.</td>
<td>Version 7</td>
<td>10/17/12: MPCTAC 11/14/12: MPCTAC 12/20/12: QIC</td>
</tr>
<tr>
<td>01/01/13</td>
<td>Review for effective date 04/01/13. References updated and changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”</td>
<td>Version 8</td>
<td>01/16/13: MPCTAC 02/21/13: QIC</td>
</tr>
<tr>
<td>08/14/13 and 08/15/13</td>
<td>Off cycle review for Well Sense Health Plan and merged policy format. Incorporate policy revisions dated 10/01/12, 11/01/12, and 01/01/13 (as specified above) for the Well Sense Health Plan 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 02/21/3) for applicable Plan products.</td>
<td>Version 9</td>
<td>08/14/13: MPCTAC (electronic vote) 08/15/13: QIC</td>
</tr>
<tr>
<td>02/01/14</td>
<td>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.</td>
<td>Version 10</td>
<td>07/01/14: MPCTAC 03/26/14: QIC</td>
</tr>
<tr>
<td>07/01/14</td>
<td>Review for effective date 10/01/14. Changed ICD9 code range for burns of multiple specified</td>
<td>Version 11</td>
<td>10/01/14: MPCTAC 07/21/14: MPCTAC (electronic vote)</td>
</tr>
</tbody>
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## Policy Revisions History

<table>
<thead>
<tr>
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<th>Code</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/15</td>
<td>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.</td>
<td>05/01/15 Version 12</td>
<td>01/21/15</td>
<td>MPCTAC</td>
</tr>
<tr>
<td>10/01/15</td>
<td>Review for effective date 12/01/15. Updated template with list of applicable products and corresponding notes.</td>
<td>12/01/15 Version 13</td>
<td>10/21/15</td>
<td>MPCTAC</td>
</tr>
<tr>
<td>10/21/15 and 11/25/15</td>
<td>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.</td>
<td>02/01/16 Version 14</td>
<td>10/21/15</td>
<td>MPCTAC</td>
</tr>
<tr>
<td>11/01/16</td>
<td>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.</td>
<td>01/01/17 Version 15</td>
<td>11/16/16</td>
<td>MPCTAC</td>
</tr>
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</table>

### Last Review Date

11/01/16

### Next Review Date

11/01/17

### Authorizing Entity

QIC

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Hyperbaric Oxygen Therapy (HBOT) in the Outpatient Setting

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Other Applicable Policies

Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
Medical Policy - *Medically Necessary*, policy number OCA 3.14
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number SCO 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.108
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31
Reimbursement Policy - *Outpatient Hospital*, policy number SCO 4.17

Reference to Applicable Laws and Regulations


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.

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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Hyperbaric Oxygen Therapy (HBOT) in the Outpatient Setting

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