POLICY STATEMENT:

I. Topical hyperbaric oxygen therapy

   Based on our criteria and review of the peer-reviewed literature, topical hyperbaric oxygen therapy has not been medically proven to be effective and is considered investigational.

II. Systemic hyperbaric oxygen therapy

   A. Based on our criteria and review of the peer-reviewed literature, systemic hyperbaric oxygen therapy in a pressurized chamber has been medically proven to be effective and therefore medically appropriate for the following indications (refer to Policy Guideline V for condition specific recommendations):

      1. Carbon monoxide poisoning, acute;
      2. Cerebral edema, acute;
      3. Crush injury with acute traumatic ischemia;
      4. Cyanide poisoning, acute;
      5. Decompression sickness;
      6. Diabetic wounds, non-healing, of the lower extremities in patients who:
         a. have type I or type II diabetes and a lower extremity wound due to diabetes; and
         b. have a wound classified as Wagner grade 3 or higher (Grade 2: ulcer penetrates to tendon, bone or joint; Grade 3: lesion has penetrated deeper than grade 2 and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths; Grade 4: gangrene of the forefoot; Grade 5: gangrene of the entire foot); and
         c. have no measurable signs of healing after 30 days of an adequate course of standard wound therapy; which includes the following:
            i. assessment of vascular status and correction of any vascular problems in the affected limb if possible;
            ii. optimization of nutritional status;
            iii. optimization of glucose control;
            iv. debridement by any means to remove devitalized tissue;
            v. maintenance of clean, moist bed of granulation tissue with appropriate moist dressings;
            vi. appropriate off-loading; and
            vii. treatment to resolve any infection that might be present.
      7. Gas embolism, acute;
      8. Gas/wet gangrene (e.g., clostridial myonecrosis);
      9. Osteomyelitis, acute, refractory (has not responded to standard medical and surgical management techniques);
     10. Osteomyelitis, chronic refractory (has persisted for at least 6 weeks or recurred after appropriate interventions - surgical debridement and at least one appropriate course of parenteral antibiotics - have been performed);
     11. Pre- and post-treatment for patients undergoing dental surgery (non-implant related) of an irradiated jaw;
     12. Profound anemia with exceptional blood loss: only when blood transfusion is impossible or must be delayed;
     13. Radiation necrosis (osteoradionecrosis and soft tissue radiation necrosis, e.g., radiation enteritis, cystitis,
B. Based on our criteria and review of the peer-reviewed literature, systemic hyperbaric oxygen therapy in a pressurized chamber has not been medically proven to be effective and is considered investigational for all other indications including, but not limited to, the following indications:

1. Acute ischemic stroke;
2. Amyotrophic Lateral Sclerosis;
3. Arterial peripheral insufficiency, acute;
4. Autism spectrum disorders;
5. Bell’s palsy;
6. Bone grafts;
7. Breast cancer, locally advanced, as pretreatment for patients undergoing chemotherapy;
8. Brown reclusive spider bites;
9. Carbon tetrachloride poisoning, acute;
10. Cardiopulmonary bypass, as pretreatment;
11. Cerebral palsy;
12. Cerebrovascular disease, acute (thrombotic or embolic) or chronic;
13. Chronic, non-healing wounds;
14. Complex regional pain syndrome;
15. Compromised skin grafts or flaps;
16. Fibromyalgia syndrome;
17. Fracture healing;
18. Frostbite;
19. Head injury, traumatic (including traumatic brain injury);
20. Hearing loss (e.g., idiopathic sudden sensorineural hearing loss) and tinnitus;
21. Hydrogen sulfide poisoning;
22. Inflammatory bowel disease (Crohn’s disease, ulcerative colitis);
23. Interstitial cystitis;
24. Intra-abdominal and intracranial abscesses;
25. In vitro fertilization;
26. Lepromatous leprosy;
27. Malignant otitis externa;
28. Meningitis;
29. Migraine;
30. Myocardial infarction and acute coronary syndrome (acute myocardial infarction and unstable angina);
31. Multiple sclerosis;
32. Muscle soreness, delayed onset;
33. Prevention of coronary restenosis;
34. Pseudomembranous colitis (antimicrobial agent-induced colitis);
35. Pyoderma gangrenosum;
36. Radiation myelitis;
37. Radiation therapy, for the purpose of tumor sensitization;
38. Retinal artery insufficiency, acute;
39. Retinal detachment;
40. Retinopathy, adjunct to scleral buckling procedures in patients with sickle cell peripheral retinopathy;
41. Sickle cell crisis and/or hematuria;
42. Soft tissue injury;

proctitis);
14. Refractory mycosis: mucormycosis, actinomycosis, canidiobolus coronato; or
15. Soft tissue infections due to mixed aerobic and anaerobic organisms, with tissue necrosis (Meleney ulcer) and refractory bacteroides.
POLICY GUIDELINES:

I. HBOT should not be a replacement for successful standard therapeutic measures. Documentation in the medical record should support the specific condition being treated with HBOT and the medical necessity of such treatment.

The following information must be documented, as applicable, to the specific medical condition:

A. Initial assessment and medical history detailing the condition requiring HBOT and a physical exam. The history should list prior treatments including antibiotic therapy and surgical interventions.

B. Current adjunctive treatment that includes treatment-type and its effectiveness.

C. Established HBOT goals.

D. HBOT session records describing physical findings and treatment rendered (including ascent time, descent time, total compression time, oxygen dose, pressurization level, documentation of attendance, and a recording of events).

E. Effect of treatment upon established HBOT goals.

II. HBOT treatments should be discontinued when either the patient heals, is unable to tolerate treatment, or fails to improve. Measurable signs of healing include shrinkage of the wound in diameter and/or depth, improvement in exudates, increased and/or improved color of granulation, and decrease in pain.

III. Continued treatment with HBOT is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

IV. Below are specific recommendations on the utilization of HBOT based upon published, peer-reviewed literature.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pressure (ATA*)</th>
<th>Patient Selection Criteria</th>
<th>Duration, Frequency and/or Number of Treatments</th>
<th>Utilization review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia, severe</td>
<td>2.0-3.0 ATA</td>
<td>When blood transfusion is impossible or must be delayed.</td>
<td>Treatments of up to 3 or 4 hours, three to four times a day. Treatment can continue with taper of time and frequency until red blood cells have been satisfactorily replaced by patient regeneration or the patient can undergo transfusion.</td>
<td>Daily</td>
</tr>
<tr>
<td>Carbon monoxide poisoning, acute</td>
<td>2.5-3.0 ATA</td>
<td>Within 6 hours of patient removal from the carbon monoxide contaminated environment.</td>
<td>One treatment; if patient has persistent neurologic dysfunction after the initial treatment further treatment can occur within 6-8 hours and can be continued once or twice daily until there is no additional improvement in cognitive function.</td>
<td>After 5 treatments</td>
</tr>
<tr>
<td>Crush injury</td>
<td>2.0-2.4 ATA</td>
<td>In conjunction with standard therapeutic measures when loss of function, limb or life is threatened and tissue oxygen tension is below 30 mmHg.</td>
<td>Three 1.5 hours treatments per day for 2 days, then twice a day for 2 days, and once daily for 2 days</td>
<td>After 20 treatments</td>
</tr>
<tr>
<td>Cyanide poisoning, acute</td>
<td>2.5-3.0 ATA</td>
<td>As an adjunct to infusion of sodium nitrite.</td>
<td>One treatment of 120 minutes.</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Pressure (ATA*)</td>
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</tr>
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<tr>
<td>Decompression sickness</td>
<td>2.0-5.0 ATA</td>
<td>Gas bubbles in the tissue or blood in volumes sufficient enough to interfere with the function of an organ or cause alteration in sensation.</td>
<td>One treatment of 1.5-14 hours duration; if patients has residual defects after the initial treatment they should receive additional treatments until clinical stability is achieved; generally no more than 5-10 treatments.</td>
<td>After 10 treatments</td>
</tr>
<tr>
<td>Diabetic wounds, non-healing</td>
<td>2.0-3.0 ATA</td>
<td>Wagner grade 3 or higher and failure of standard wound therapy for at least 30 consecutive days.</td>
<td>90 minute treatments, 5 days per week are performed in conjunction with continuing standard wound care; may last for 30-40 treatments.</td>
<td>After 20 treatments</td>
</tr>
<tr>
<td>Gas embolism, acute</td>
<td>High to low pressure mixed gases</td>
<td>Gases in the vasculature sufficient enough to interfere with the function of an organ and results in ischemia to the affected areas.</td>
<td>Treatment is typically 1-2 treatments but occasionally up to 5-10; treatment continues until no additional improvement is seen.</td>
<td>After 10 treatments</td>
</tr>
<tr>
<td>Gas gangrene (e.g., clostridial myonecrosis)</td>
<td>3.0 ATA</td>
<td>Positive gram stained smear or culture from tissue fluids, tissue gas visualization on x-ray, severe and sudden pain, skin changes, and edema.</td>
<td>Three 90-minute treatments during the first 24 hours and then two treatments per day for the next 2-5 days.</td>
<td>After 10 treatments</td>
</tr>
<tr>
<td>Osteomyelitis, chronic, refractory</td>
<td>2.0-2.5 ATA</td>
<td>Infection persisted for at least 6 weeks or recurred after surgical debridement and at least one appropriate course of parenteral antibiotics have been performed.</td>
<td>Daily treatment for 90-120 minutes and can be continued for 4-6 weeks for patients who respond to initial treatment with antibiotics, surgical debridement and hyperbaric oxygen therapy.</td>
<td>After 30-40 sessions</td>
</tr>
<tr>
<td>Osteoradionecrosis</td>
<td>2.0-2.5 ATA</td>
<td>As adjunctive treatment in the preoperative and postoperative management of the patient.</td>
<td>30 treatments followed by only minor bony debridement. If response is adequate, an additional 10 treatments can be given. If patients are not responding they are considered stage II and receive more extensive surgical debridement then 10 additional treatments. Stage III patients receive 30 treatments followed by mandibular segmental resection and then 10 additional treatments.</td>
<td>After 10-30 treatments</td>
</tr>
</tbody>
</table>
### Condition | Pressure (ATA*) | Patient Selection Criteria | Duration, Frequency and/or Number of Treatments | Utilization review
--- | --- | --- | --- | ---
Osteoradionecrosis, mandibular | 2.0-2.5 ATA | Evidence of overt fracture or bony resorption. | Initial treatment for stage I patients is 30 treatments. If response is adequate 10 additional treatments can be provided. Non-responders are considered stage II and receive more extensive surgical debridement followed by 10 additional treatments. Patients with stage III disease can receive up to 30 treatments followed by mandibular segmental resection and then an additional 10 treatments. | After 10-30 treatments

Refractory mycosis (e.g., actinomycosis, mucormycosis) | 2.0-2.5 ATA | In conjunction with standard treatment when the disease process is refractory to antibiotics and surgical treatment. | One to two times daily for 90-120 minutes; treatment can continue for up to 40-80 treatments. | After 10-30 treatments

Soft-tissue infection with necrosis | 2.0-2.5 ATA | Adjunctive therapy only in patients where morbidity and mortality are expected to be high despite aggressive standard treatment. | Twice daily for 90 to 120 minutes until condition is stabilized, then once daily. | After 30 treatments

*1 ATA (atmospheres absolute) = pressure of 760 mmHg, 14.7 psi, 760 torr, or 33 ft of seawater.

Information relating to the frequency of treatment and other treatment specifics can also be found at the web site of the Undersea & Hyperbaric Medical Society (UHMS) [https://www.uhms.org/resources/hbo-indications.html].

VI. It is recommended the Centers for Medicare and Medicaid Services (CMS) criteria for coverage be utilized in determining appropriate practitioners to render hyperbaric oxygen therapy. The CMS criteria states:

A. Qualified non-physician practitioners (NPPs) may supervise hyperbaric oxygen therapy services, if such service is included within their State scope of practice, if their required supervision or collaborative agreement is with a physician qualified to provide HBOT services, and if the NPP meets the educational requirements identified within the coverage article.

B. Physicians supervising hyperbaric oxygen therapy should be certified in Undersea and Hyperbaric Medicine by the American Board of Emergency Medicine (ABEM) or the American Board of Preventive Medicine (APBM) or the American Osteopathic Conjoint Committee of Undersea and Hyperbaric Medicine (AOCUHM); or must have completed a minimum 40-hour training experience in a program such as one approved by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society.

C. Advanced Cardiac Life Support (ACLS) training and certification of supervising physicians (and NPPs) is required in physician offices and off-campus hospital sites; and in on-campus provider-based departments for which provider-response time to the chamber can be expected to exceed five minutes.

D. HBO therapy rendered within a hospital outpatient department is considered “incident to” a physician’s or qualified NPP’s services and requires physician supervision. The physician supervision requirement is presumed to be met when services are performed on the hospital premises (i.e., certified as part of the hospital and part of the hospital campus); however, in all instances, it is recommended that the physician be present during the ascent and descent portions of each treatment.
E. In order to satisfy the immediately available criteria, for HBO therapy performed in an outpatient hospital on-campus or off-campus provider based department, the physician (or qualified NPP) must be present in the office suite or at a location with a maximum of a five (5) minute response time to the chamber. For HBO performed in a physician office, the physician (or qualified NPP) must be present in the office suite.

VII. The Federal Employee Health Benefit Program (FEHBP/FEP) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only on the basis of their medical necessity.

DESCRIPTION:

Hyperbaric oxygen therapy (HBOT) is a technique of delivering highly pressurized oxygen to the tissues. Two methods of administration are available.

In systemic, or large chamber hyperbaric oxygen, the patient is entirely enclosed in a pressure chamber and breathes oxygen at a pressure greater than one atmosphere (the pressure of \( \text{O}_2 \) at sea level). This technique relies on the systemic circulation to deliver highly oxygenated blood to the target site, typically a wound. In addition, systemic hyperbaric oxygen therapy can be used to treat systemic illness such as air or gas embolism, carbon monoxide poisoning, clostridial gas gangrene, etc. Treatment may be carried out either in a monoplace (single person) chamber pressurized with pure \( \text{O}_2 \) or in a larger, multi-place (multi-person) chamber pressurized with compressed air, in which case the patient receives pure oxygen by mask, head tent, or endotracheal tube.

Topical hyperbaric oxygen therapy describes a technique of delivering 100% \( \text{O}_2 \) directly to a wound site at a pressure slightly higher than atmospheric pressure. It is hypothesized that the high concentrations of oxygen diffuse directly into the wound to increase the local cellular oxygen tension, which in turn promotes wound healing. Topical HBOT devices consist of an appliance to enclose the wound area and a source of \( \text{O}_2 \); conventional \( \text{O}_2 \) tanks may be used. The appliances may be disposable and may be used without supervision in the home by well-trained patients. Topical HBO has been investigated as a treatment for skin ulcerations due to diabetes, venous stasis, post-surgical infection, gangrenous lesion, decubitus ulcers, amputations, skin graft or frostbite.

RATIONALE:

Hyperbaric oxygen therapy is a procedure; therefore it is not subject to U.S. Food and Drug Administration (FDA) regulation. The hyperbaric chambers used to administer the therapy do require and have received FDA approval.

HBOT for autism spectrum disorders. In 2009, a double-blind, randomized controlled study on the use of HBOT to treat children with autism was published and included 62 children, ages 2-7, diagnosed with an autistic disorder. The active group received hyperbaric treatment at 1.3 atmospheres (atm) and 24% oxygen in a hyperbaric chamber. The control group received a sham treatment consisting of 1.03 atm and ambient air (21% oxygen). Both groups received 40 sessions of active or sham treatment lasting 60 minutes each over a period of 4 weeks. After completion of the 4-week study, families with children in the control group were offered the active intervention. The outcomes were change compared to baseline after 4 weeks several scales: Aberrant Behavior Checklist (ABC); Autism Treatment Evaluation Checklist (ATEC); and Clinical Global Impression-Improvement (CGI). There was no significant differences between-group improvement on the ABC total score, any of the ABC subscales or on the ATEC total score. Compared to the control group, the treatment group had a significant improvement in the ATEC sensory/cognitive awareness subscale. On the physician-rated CGI total score, 30% of the children in the treatment group had a score of 1 (very much improved) or 2 (much improved) compared to 8% in the control group. On the parental-rated CGI total score, 30% of the children in the treatment group had a score of 1 or 2 compared to 15% in the control group. Among the parental-rated CGI subscales, significantly more children were rated as improved in the treatment group compared to control on 2 out of 18 subscales, receptive language and eye contact. A key limitation of the study was that the authors reported outcomes only directly after completion of the intervention. Whether there are any long-term effects is not known. Additional follow-up data cannot be obtained because members of the control group crossed over to the intervention after 4 weeks. Other limitations include lack of adjustment for multiple comparisons and unclear clinical significance of the statistically significant outcomes. Findings suggest improvements may be seen in some children with autism treated with HBOT, but
when results are compared to a control group, no difference was found as measured by the three clinical instruments. Further research is needed to determine if HBOT is an effective treatment for autism. (Rossignol, et al., 2009)

In December 2009, the Undersea and Hyperbaric Medical Society issued a position paper stating they do not recommend routine treatment of autism with HBOT as there is very little evidence to support an effect of pressure alone or that oxygen has differing effects whether given by increasing ambient pressure or increasing the inspired fraction.

A 2016 Chochrane review by Xiong et al identified 1 RCT evaluating systemic HBOT for people with autism spectrum disorder who met reviewers’ eligibility criteria and that trial did not find significantly improved outcomes with HBOT versus sham. The authors concluded that there is no evidence that hyperbaric oxygen therapy improves core symptoms and associated symptoms of ASD. Adding that it is important to note that adverse effects (minor-grade ear barotrauma events) can occur. Given the absence of evidence of effectiveness and the limited biological plausibility and possible adverse effects, the need for future RCTs of hyperbaric oxygen therapy must be carefully considered.

The use of HBOT for patients with chronic refractory osteomyelitis is supported by the Undersea and Hyperbaric Medical Society and the American College of Hyperbaric Medicine. Although no randomized clinical trials examining the effects of HBOT on chronic refractory osteomyelitis have been identified the substantial majority of available human case series and non-randomized prospective trials suggest that the addition of HBOT to routine surgical and antibiotic management in previously refractory osteomyelitis is safe and improves the ultimate rate of infection resolution.

HBOT for Idiopathic Sudden Sensorineural Hearing Loss: In 2015, an evidence-based literature review was reported that addresses the controversies in the management of sudden sensorineural hearing loss and proposes a treatment algorithm based on the highest quality evidence. The authors concluded if the hearing loss is idiopathic in nature patients may be offered a course of oral steroid. If systemic steroids are contraindicated and/or there is no improvement with initial oral therapy, intratympanic steroids as either primary or salvage therapy may be considered. They stated the cost, limited availability and lack of strong evidence for HBOT makes it impractical at present. (Lawrence, et al. 2015)

HBOT for radiation necrosis and osteoradionecrosis. Given the limited number of options available to patients with these late effects of radiation therapy, results of cohort studies as well as randomized trials were used in evaluating clinical evidence. A retrospective case series of 65 patients with radiation enteritis/proctitis and 94 patients with cystitis were reported from one institution. Response was better in patients receiving 30 or more total treatments compared with fewer treatments. A Cochrane Review of randomized trials concluded that available small trials suggest that for people with late radiation tissue injury affecting the head, neck, anus and rectum, HBOT is associated with improved outcomes. HBOT also appears to reduce the change of osteoradionecrosis following tooth extraction in an irradiated field.

Published clinical trials have not provided evidence to support the efficacy and safety of hyperbaric oxygen therapy over current treatment options for the indications listed as investigational in this policy.

CODES: 
Number Description

Eligibility for reimbursement is based upon the benefits set forth in the member’s subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).

CPT: 99183 Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session

HCPCS: A4575 (E/I) Topical hyperbaric oxygen chamber, disposable
G0277 Hyperbaric oxygen under pressure, full body chamber, per 30 minute
interval

E0446 (E/I) Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories

ICD9:

039.0-039.4 Actinomycotic infections (code range)
039.8-039.9
040.0 Gas gangrene
090.0 Early congenital syphilis, symptomatic
095.5 Syphilis of bone
111.0-111.3 Dermatomycosis, other and unspecified (code range)
111.8-111.9
112.0-112.5 Candidiasis (mucomycosis) (code range)
112.81-112.9
117.9 Other and unspecified mycoses
250.80-250.83 Diabetic osteomyelitis
285.1 Acute posthemorrhagic anemia
348.5 Cerebral edema
376.03 Orbital osteomyelitis
526.4 Osteomyelitis of jaw
526.89 Osteoradionecrosis of jaw
682.0-682.9 Other cellulitis and abscess (code range)
686.00-686.9 Other local infections of skin and subcutaneous tissue (code range)
730.00-730.29 Osteomyelitis (code range)
730.80-730.89 Other infections involving bone (osteomyelitis) in disease classified elsewhere (code range)
730.90-730.99 Unspecified infection of bone (code range)
767.8 Cerebral edema, fetus or newborn (due to birth injury)
785.4 Gangrene
909.2 Late effect of radiation
925.1-925.2 Crush injury (code range)
958.0 Gas (air) embolism, acute
986.0 Toxic effect of carbon monoxide poisoning
987.7 Toxic effect of other gases, fumes or vapors, hydrocyanic acid gas
989.0 Toxic effect of other substances, chiefly nonmedical as to source, cyanide poisoning, acute
990 Effects of radiation, unspecified
993.3 Decompression sickness (Caisson Disease)
<table>
<thead>
<tr>
<th>ICD10</th>
<th>Medically Appropriate codes per Policy Statement IIA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>996.52</td>
<td>Mechanical complication of other specified prosthetic device, implant, graft due to graft of other tissue</td>
</tr>
<tr>
<td>996.69</td>
<td>Infection and inflammatory reaction due to internal prosthetic device, implant and graft</td>
</tr>
<tr>
<td>996.79</td>
<td>Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft due to other internal prosthetic device, implant, and graft</td>
</tr>
</tbody>
</table>

A18.01 Tuberculosis of spine
A18.03 Tuberculosis of other bones
A42.0-A42.2 Actinomycosis (code range)
A42.81-A42.89 Other forms of actinomycosis (code range)
A42.9 Actinomycosis, unspecified
A43.0-A43.9 Nocardiosis (code range)
A48.0 Gas gangrene
A50.01-A50.09 Early congenital syphilis, symptomatic (code range)
A52.77 Syphilis of bone and joint
B36.0-B36.9 Other superficial mycoses (code range)
B47.1-B47.9 Mycetoma (code range)
B48.3 Geotrichosis
B48.8 Other specified mycoses
B49 Unspecified mycosis
D62 Acute posthemorrhagic anemia
E08.52 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E09.52 Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.618-E10.69 Type 1 diabetes mellitus with other specified complications (code range)
E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11-618-E11.69 Type 2 diabetes mellitus with other specified complication
E13.52-E13.69 Other specified diabetes mellitus (code range)
G93.6 Cerebral edema
H05.021-H05.029 Osteomyelitis of orbit (code range)
I70.361-I70.769 Atherosclerosis of bypass graft(s) of the extremities with gangrene (code range)

Proprietary Information of Excellus Health Plan, Inc.
I70.461-I70.469 Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene (code range)
I73.01 Raynaud's syndrome with gangrene
I96 Gangrene, not elsewhere classified
K12.2 Cellulitis and abscess of mouth
L02.01-L02.91 Cutaneous abscess (code range)
L03.111-L03.119 Cellulitis (code range)
L03.121-L03.129 Acute lymphangitis (code range)
L03.211-L03.91 Cellulitis and acute lymphangitis (code range)
L08.1 Erythrasma
L59.9 Disorder of the skin and subcutaneous tissue related to radiation, unspecified
L98.3 Eosinophilic cellulitis (Wells)
M27.2 Inflammatory conditions of jaws
M27.8 Other specified diseases of jaws
M46.20-M46.28 Osteomyelitis of vertebra (code range)
M46.30-M46.39 Infection of intervertebral disc (pyogenic) (code range)
M86.00-M86.09 Acute hematogenous osteomyelitis (code range)
M86.10-M86.19 Other acute osteomyelitis (code range)
M86.20-M86.29 Subacute osteomyelitis (code range)
M86.30-M86.69 Chronic osteomyelitis (code range)
M86.8x0-M86.9 Other and unspecified osteomyelitis (code range)
M90.80-M90.89 Osteopathy in diseases classified elsewhere (code range)
P11.0 Cerebral edema due to birth injury
S06.1x0A- S06.1x9A Traumatic cerebral edema without loss of consciousness (code range)
S07.0xxA, S17.9xxA, Crushing injury (code range)
T57.3x1A- T57.3x4A Toxic effect of hydrogen cyanide (code range)
T58.01xA- T58.94xA Toxic effect of carbon monoxide (code range)
T65.0x1A- T65.0x4A Toxic effect of cyanides (code range)
T66.xxxA Radiation sickness, unspecified, initial encounter
T70.3xA Caisson disease (decompression sickness), initial encounter
T79.0xxA Air embolism (traumatic), initial encounter
T86.820-T86.822 Complications of skin graft (allograft) (autograft) (code range)
T86.828-T86.829 Other and unspecified complications of skin graft (allograft) (autograft)
ICD10: Investigational codes per Policy Statement IIB Codes may not be all inclusive):
- G12.21 Amyotrophic lateral sclerosis
- F84.0 Autistic disorder
- G51.0 Bell’s palsy
- T63.333A-T63.332S Toxic effect of venom of brown recluse spider (code range)
- T53.0X1A-T53.0X2S Toxic effects of carbon tetrachloride (code range)

REFERENCES:


SUBJECT: HYPERBARIC OXYGEN THERAPY (HBOT)

POLICY NUMBER: 2.01.07
CATEGORY: Technology Assessment

EFFECTIVE DATE: 11/19/99
REVISED DATE: 04/17/02, 04/24/03, 05/19/04, 07/21/05, 09/21/06, 07/19/07, 06/19/08, 09/18/08, 09/17/09, 02/17/11, 04/19/12, 03/21/13, 03/20/14, 03/19/15, 03/17/16, 04/20/17


KEY WORDS:
HBOT, Systemic hyperbaric oxygen therapy, Topical hyperbaric oxygen pressurization, Topical hyperbaric oxygen therapy, Topical oxygen wound therapy, TOWT.

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**CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS**

There is currently a National Coverage Determination (NCD) and a Local Coverage Article for Hyperbaric Oxygen Therapy. Please refer to the following websites for Medicare Members:

NCD:
https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=12&ncdver=3&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=hyperbaric&KeyWordLookUp=Title&KeyWordSearchType=And&articleId=52174&ver=24&ContrId=298&ContrVer=1&bc=gAAAABAABAAAAAAA%3d%3d&

LCA: