

## Clinical Policy: Hyperbaric Oxygen Therapy

Reference Number: WA.CP.MP.27

Date of Last Revision: 05/22

Effective Date: 06/01/22

[Coding Implications](#)

[Revision Log](#)

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### Description

This policy describes the medical necessity guidelines for hyperbaric oxygen therapy (HBOT).

### Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's (HCA) Billing Guidelines, that hyperbaric oxygen therapy is considered **medically necessary** for any of the following conditions:
  - A. Decompression sickness
  - B. Acute carbon monoxide poisoning
  - C. Acute cyanide poisoning
  - D. Acute gas or air embolism
  - E. Gas gangrene (clostridial myositis and myonecrosis)
  - F. Progressive necrotizing soft tissue infections
  - G. Acute traumatic ischemia secondary to crush injuries
    - i. For prevention or loss of function or for limb salvage
    - ii. Used in combination with standard medical and surgical management
  - H. Late radiation tissue injury
  - I. Prevention of osteoradionecrosis following tooth extraction in a previously radiated field
  - J. Compromised skin grafts and flaps for prevention of loss of function or for limb salvage,
  - K. Refractory osteomyelitis unresponsive to conventional medical and surgical management,
  - L. Non-healing diabetic wounds when all three of the following criteria are met:
    - i. Type I or Type II diabetes and a lower extremity wound that is due to diabetes,
    - ii. Wound is classified as Wagner grade III or higher, and
    - iii. Failure of adequate course of standard wound therapy.
- II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that hyperbaric oxygen therapy is considered **not medically necessary** for:
  - A. Traumatic or chronic brain injury
  - B. Cerebral palsy
  - C. Multiple sclerosis
  - D. Migraine or cluster headaches
  - E. Acute or chronic sensorineural hearing loss
  - F. Thermal burns
  - G. Non-healing venous, arterial or pressure ulcers.

### Background

This policy is based on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are 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.

CPT® Codes	Description
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session

HCPCS Codes	Description
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed. Previous corporate policy (CP.MP.27) archived 3/1/2020 in favor of using <i>InterQual</i> .	10/20	11/20
Policy updated to reflect HCA Billing Guideline rather than <i>InterQual</i> . “Members” updated to “Members/Enrollees”. References updated.	10/21	11/21
Policy reviewed and verified variances from <i>InterQual</i> justify maintenance. References reviewed and updated. Changed “date” in the revision log header to “revision date”.	04/22	05/22

**References**

- Hayes, Inc. *Hyperbaric Oxygen Therapy for Tissue Damage, Including Wound Care and Treatment of Central Nervous System Conditions*. Washington State Health Care Authority. 2013 Feb 15.
- Washington State Health Care Authority. Physician-related Services/Health Care Billing Guide. <https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-serv-bg-20220401.pdf> Revision effective April 1, 2022.

**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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members/enrollees**, 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.

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