


<b>MEDICAL POLICY</b>	<b>Hyperbaric Oxygen Therapy (Medicare Only)</b>
<b>Effective Date: 8/01/2022</b>	Medical Policy Number: 198
 8/1/2022	Medical Policy Committee Approved Date: 5/18; 3/19; 5/19; 06/2020; 07/2021; 7/2022
Medical Officer	Date

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Medicare only

**DOCUMENTATION REQUIREMENTS:**

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) requires documentation of all previous and ongoing standard wound (and other) treatment(s) for the patient’s specific condition. Each hyperbaric oxygen treatment must be completely documented including the ascent and descent time, patient toleration, and ongoing progress.

**MEDICARE POLICY CRITERIA**

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Hyperbaric Oxygen Therapy (HBOT)</i>	National Coverage Determination (NCD) for Hyperbaric Oxygen Therapy ( <a href="#">20.29</a> )
<i>Topical Hyperbaric Oxygen (E0446 and A4575)</i>	Local Coverage Determination (LCD): Oxygen and Oxygen Equipment ( <a href="#">L33797</a> )

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**BILLING GUIDELINES**

General

*HBOT Used for the Treatment of Diabetic Wounds of the Lower Extremities*

For more information regarding submitting claims for HBOT used for the treatment of diabetic wounds of the lower extremities, see the *Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, §30.1 - Billing Requirements for HBO Therapy for the Treatment of the Lower Extremities.*

*Topical Hyperbaric Oxygen*

According to the Noridian LCA Billing and Coding: Topical HBO and Physician Related Service Billing and Coding Guidelines (A56026), “the two HCPCS codes for topical oxygen therapy (E0446 and A4575) are designated as DME jurisdiction” and that physicians are not allowed to report for topical oxygen HCPCS codes. In addition, the *Medicare Claims Processing Manual, Chapter 32, §30.2 Hyperbaric Oxygen (HBO) Therapy (Section C, Topical Application of Oxygen)* states, “there shall be no coverage for any separate or additional physician’s professional services related to this procedure.” According to LCA A56026, to bill for related **physician** services of topical oxygen, unlisted CPT code 99199 would be used, but no separate reimbursement would be allowed.

**CPT/HCPCS CODES**

<b>Medicare Only</b>	
Prior Authorization Required	
99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
Not Covered	
A4575	Topical hyperbaric oxygen chamber, disposable
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories
Unlisted Codes	
All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then <b>prior-authorization is required.</b>	
99199	Unlisted special service, procedure or report

## **INSTRUCTIONS FOR USE**

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

## **REGULATORY STATUS**

### Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.