DRAFT Local Coverage Determination (LCD) for Hyperbaric Oxygen (HBO) Therapy (DL34794)

[PROPOSED/DRAFT]

Contractor Information

Contractor Name

Novitas Solutions, Inc.

Contract Number

12501, 12502, 12101, 12102, 12201, 12202, 12301, 12302, 12401, 12402, 12901
04911, 07101, 07102, 07201, 07202, 07301, 07302, 04111, 04112, 04211, 04212, 04311, 04312, 04411, 04412

Contract Type

MAC - Part A and Part B

Proposed/Draft LCD Information

Document Information

[PROPOSED/DRAFT]

Proposed LCD ID

DL34794

Proposed LCD Title

Hyperbaric Oxygen (HBO) Therapy

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Jurisdiction
CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

CMS Internet-Only Manual Publication 100-03, Chapter 1, Section 20.29.

CMS Internet-Only Manual Publication 100-04, Chapter 32, Section 30.

Coverage Guidance

Coverage Indications, Limitations and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

The following conditions meet coverage indications per National Coverage Determination (NCD) 20.29:

Covered Conditions

Note: Conditions marked with ** are covered only when provided in the inpatient setting.

- **Acute carbon monoxide intoxication (ICD-9-CM diagnosis code 986):**

  Acute carbon monoxide intoxication induces hypoxic stress. The cardiac and central nervous systems are the most susceptible to injury from carbon monoxide. The administration of supplemental oxygen is essential treatment. Hyperbaric oxygen causes a higher rate of dissociation of carbon monoxide from hemoglobin than can occur breathing pure air at sea level pressure. The chamber compressions should be between 2.5 and 3.0 atm. It is not uncommon in patients with persistent neurological dysfunction to require subsequent treatments within six to eight hours, continuing once or twice daily until there is no further improvement in cognitive functioning. This is an emergent condition requiring the physician to be **immediately** available to furnish assistance and direction throughout the performance of the procedure.

- **Decompression illness (ICD-9-CM diagnosis codes 993.2 and 993.3):**

  Decompression illness arises from the formation of gas bubbles in tissue or blood in volumes sufficient enough to interfere with the function of an organ or to cause alteration in sensation. The cause of this enucleated gas is rapid decompression during ascent. The clinical manifestations range from skin eruptions to shock and death. The circulating gas emboli may be heard with a Doppler device. Treatment of choice for decompression illness is HB02 with mixed gases. The result is immediate reduction in the volume of bubbles. The treatment prescription is highly variable and case-specific. The depths could range between 60 to 165 feet of seawater for durations of 1.5 to more than 14 hours. The patient may or may not require repeat dives. This is an emergent condition requiring the physician to be **immediately** available to furnish assistance and direction throughout the performance of the procedure.
**Gas embolism (ICD-9-CM diagnosis codes 958.0 and 999.1):**

Gas embolism occurs when gases enter the venous or arterial vasculature embolizing in a large enough volume to compromise the function of an organ or body part. This occlusive process results in ischemia to the affected areas. Air embolism may occur as a result of surgical procedures (e.g., cardiovascular surgery, infra-aortic balloons, arthroplasties or endoscopies), use of monitoring devices (e.g., Swan-Ganz introducer, infusion pumps) in non-surgical patients (e.g., ruptured lung in respirator-dependent patient, injection of fluids into tissue space) or traumatic injuries (e.g., gunshot wound, penetrating chest injuries). In these cases, HBO therapy may be the treatment of choice. It is most effective when initiated early. Therapy is directed toward reducing the volume of gas bubbles and increasing the diffusion gradient of the embolized gas. Treatment modalities range from high-pressure to low-pressure mixed gas dives. This is an emergent condition requiring the physician to be immediately available to furnish assistance and direction throughout the performance of the procedure.

**Gas gangrene (ICD-9-CM diagnosis code 040.0):**

Gas gangrene is an infection caused by the clostridium bacillus, the most common being clostridium perfringens. Clostridial myositis and myonecrosis (gas gangrene) is an acute, rapidly growing invasive infection of the muscle. It is characterized by profound toxemia, extensive edema, massive death of tissue and a variable degree of gas production. The most prevalent toxin is the alpha-toxin which in itself is hemolytic, tissue-necrotizing and lethal. The diagnosis of gas gangrene is based on clinical data supported by a positive (Gram-stained) smear obtained from tissue fluids; X-ray radiographs, if obtained, can visualize tissue gas.

The onset of gangrene can occur one to six hours after injury and presents with severe and sudden pain at the infected area. The skin overlying the wound progresses from shiny and tense to dusky, then bronze in color. The infection can progress as rapidly as six inches per hour. Hemorrhagic vesicles may be noted. A thin, sweet-odored exudate is present. Swelling and edema occur. The non-contractile muscles progress to dark red to black in color.

The acute problem in gas gangrene is stopping the rapidly advancing infection caused by alpha-toxin and to continue treatment until the advancement of the disease process has been arrested. The goal of HBO therapy is to stop alpha-toxin production, thereby inhibiting further bacterial growth at which point the body can use its own host defense mechanisms. HBO treatment starts as soon as the clinical picture presents and is supported by a positive Gram-stained smear. A treatment approach utilizing HBO is an adjunct to antibiotic therapy and surgery. Initial surgery may be limited to opening the wound. Debridement of necrotic tissue can be performed between HBO treatments when clear demarcation between dead and viable tissue is evident. The usual treatment consists of oxygen administered at 3.0 atm pressure for 90 minutes, three times in the first 24 hours. Over the next four to five days, treatment sessions twice a day are usual. The sooner HBO treatment is initiated, the better the outcome is in terms of life, limb and tissue saving. This is an emergent condition requiring the physician to be immediately available to furnish assistance and direction throughout the performance of the procedure.

**Acute Traumatic Peripheral Ischemia (ATPI) (ICD-9-CM diagnosis codes 902.53, 903.1, 903.01 904.0 and 904.41):**

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.

**Crush injuries and suturing of severed limbs (ICD-9-CM diagnosis codes 927.00–927.03, 927.09–927.11, 927.20–927.21, 927.8–927.9, 928.00–928.01, 928.10–928.11, 928.20–928.21, 928.3, 928.8–928.9, 929.0, 929.9, and 996.90–996.96, 996.99):**

As in the previous condition, HBO therapy would be an adjunctive treatment when loss of function, limb or life is threatened.
Acute traumatic ischemia is the result of injury by external force or violence compromising circulation to an extremity. The extremity is then at risk for necrosis or amputation. Secondary complications are frequently seen: infection, non-healing wounds and non-united fractures. The goal of HBO therapy is to enhance oxygen at the tissue level to support viability. When tissue oxygen tensions fall below 30 mmHg, the body’s ability to respond to infection and wound repair is compromised. Using HBO at 2–2.4 atm, the tissue oxygen tension is raised to such a level that the body’s responses can become functional again. The benefits of HBO for this indication are enhanced tissue oxygenation, edema reduction and increased oxygen delivery per unit of blood flow, thereby reducing the complication rates for infection, non-union and amputation.

The usual treatment schedule is three 1.5-hour treatment periods daily for the first 48 hours. Additionally, two 1.5-hour treatment sessions daily for the next 48 hours may be required. On the fifth and sixth days of treatment, one 1.5-hour session would typically be used. At this point in treatment, outcomes of restored perfusion, edema reduction and either demarcation or recovery would be sufficient to guide discontinuing further treatments.

For acute traumatic peripheral ischemic, crush injuries and suturing of severed limbs, 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. This is an emergent condition requiring the physician to be immediately available to furnish assistance and direction throughout the performance of the procedure.

**Progressive necrotizing infections (necrotizing fasciitis) (ICD-9-CM diagnosis code 728.86):**

The principal treatment for progressive necrotizing infections is surgical debridement and systemic antibiotics. HBO is recommended as an adjunct only in those settings where mortality and morbidity are expected to be high despite aggressive standard treatment of the necrotizing infections. This condition is a relatively rare infection. It is usually a result of a group A streptococcal infection beginning with severe or extensive cellulitis that spreads to involve the superficial and deep fascia, producing thrombosis of the subcutaneous vessels and gangrene of the underlying tissues. A cutaneous lesion usually serves as a portal of entry for the infection, but sometimes no such lesion is found. This is an emergent condition requiring the physician to be immediately available to furnish assistance and direction throughout the performance of the procedure.

**Acute Peripheral Arterial Insufficiency (ICD-9-CM diagnosis codes 444.21, 444.22 and 444.81):**

Acute peripheral arterial insufficiency is defined as the sudden occlusion of a major artery in an extremity such as the femoral or brachial artery (e.g., saddle embolus). Emergent surgery is the treatment of choice. The goal of HBO therapy is to enhance oxygen at the tissue level to support viability until a definitive procedure can be performed (e.g., surgery). Using HBO at 2–2.4 atm, the tissue oxygen tension is raised to such a level that the body’s responses can become functional again. The benefits of HBO for this indication are enhanced tissue oxygenation, edema reduction and increased oxygen delivery per unit of blood flow, thereby enhancing limb preservation. This is an emergent condition requiring the physician to be immediately available to furnish assistance and direction throughout the performance of the procedure.

**Preparation and preservation of compromised skin grafts (ICD-9-CM diagnosis code 996.52; excludes artificial skin):**

HBO is utilized for graft or flap salvage in cases where hypoxia or decreased perfusion has compromised viability of an existing skin graft. HBO enhances flap survival. Treatments are given at a pressure of 2.0 to 2.5 atm lasting from 90–120 minutes. It is not unusual to receive treatments twice a day. When the graft or flap appears stable, treatments are reduced to daily. Medicare coverage does not apply to the initial preparation of the body site for a graft. HBO therapy is not necessary for normal, uncompromised skin grafts or flaps or for primary management of wounds.

**Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management (ICD-9-CM
HBO is an adjunctive therapy for chronic refractory osteomyelitis that persists or recurs following treatment with primary or first-line interventions. Primary/first-line interventions include antibiotics, aspiration of the abscess, immobilization of the affected extremity and surgery. The hallmarks of chronic refractory osteomyelitis include a nidus of infected dead bone or scar tissue, an ischemic soft tissue envelope and a refractory clinical course (defined as failure after standard surgical debridement and at least six weeks of appropriate antibiotic therapy). HBO is not to be used alone but as an adjunctive therapy in combination with antibiotics. Antibiotics are chosen on the basis of bone culture and sensitivity studies. HBO can elevate the oxygen tensions found in infected bone to normal or above-normal levels. This mechanism enhances healing and the body's antimicrobial defenses. It is believed that HBO augments the efficacy of certain antibiotics (gentamicin, tobramycin and amikacin). Finally, the body's osteoclast function of removing necrotic bone is dependent on a proper oxygen tension environment; HBO provides this environment. HBO treatments are delivered at a pressure of 2.0 to 2.5 atm for a duration of 90–120 minutes. It is not unusual to receive daily treatments following major debridement surgery. The number of treatments required varies on an individual basis. Medicare Parts A and B can cover the use of HBO for chronic refractory osteomyelitis that has been demonstrated to be unresponsive to conventional medical and surgical management.

- **Osteoradionecrosis as an adjunct to conventional treatment (ICD-9-CM diagnosis code 526.89):**

HBO use in the treatment of osteoradionecrosis and soft tissue radionecrosis is one part of an overall plan of care. Also included in this plan of care are debridement or resection of non-viable tissues in conjunction with antibiotic therapy. Soft tissue flap reconstruction and bone grafting may also be indicated. The goal of HBO treatment is to increase the oxygen tension in both hypoxic bone and tissue to stimulate growth in functioning capillaries, fibroblastic proliferation and collagen synthesis. The recommended daily treatments last 90–120 minutes at 2.0 to 2.5 atm. The duration of HBO therapy is highly individualized.

- **Cyanide poisoning (ICD-9-CM diagnosis code 987.7 and 989.0):**

Cyanide poisoning carries a high risk of mortality. Victims of smoke inhalation frequently suffer from both carbon monoxide and cyanide poisoning. The traditional antidote for cyanide poisoning is the infusion of sodium nitrite. This treatment can potentially impair the oxygen-carrying capacity of hemoglobin. Using HBO as an adjunct therapy adds the benefit of increased plasma-dissolved oxygen. HBO benefit for the pulmonary injury related to smoke inhalation remains experimental. The HBO treatment protocol is to administer oxygen at 2.5 to 3.0 atm for up to 120 minutes during the initial treatment. Most patients with combination cyanide and carbon monoxide poisoning will receive only one treatment. This is an emergent condition requiring the physician to be immediately available to furnish assistance and direction throughout the performance of the procedure.

- **Actinomycosis only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment (ICD-9-CM diagnosis codes 039.0–039.4, 039.8 and 039.9):**

Actinomycosis is a bacterial infection caused by Actinomyces israelii. Its symptoms include slow-growing granulomas that later break down, discharging viscid pus containing minute yellowish granules. The treatment includes prolonged administration of antibiotics (penicillin and tetracycline). Surgical incision and draining of accessible lesions is also helpful. Only after the disease process has been shown refractory to antibiotics and surgery could HBO be covered by Medicare.

- **Diabetic wounds of the lower extremities (ICD-9-CM codes for diabetic complications (250.70–250.73 or 250.80–250.83) must be listed in addition to a covered wound diagnosis code (707.10-707.15, or 707.19) to indicate this condition. See National Coverage Determination (NCD) 20.29 coverage criterion below.**


For dates of service on or after April 1, 2003, HBO therapy is covered for diabetic wounds of the lower extremities in patients who meet the following three criteria per NCD 20.29:

- 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.

**Non-Covered Conditions per NCD 20.29**

No program payment may be made for HBO in the treatment of the following conditions:

- Cutaneous, decubitus and stasis ulcers.
- Chronic peripheral vascular insufficiency.
- Anaerobic septicemia and infection other than clostridial.
- Skin burns (thermal).
- Senility.
- Myocardial infarction.
- Cardiogenic shock.
- Sickle cell anemia.
- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency.
- Acute or chronic cerebral vascular insufficiency.
- Hepatic necrosis.
- Aerobic septicemia.
- Tetanus.
- Systemic aerobic infection.
- Organ transplantation.
- Organ storage.
- Pulmonary emphysema.
- Exceptional blood loss anemia.
- Multiple sclerosis.
- Arthritic disease.
- Acute cerebral edema.
Topical Application of Oxygen

The topical application method of oxygen administration does not meet the definition of HBO therapy. Its clinical efficacy has not been established therefore, payment for this method is not allowed.

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Evaluation and Management (E/M) Service

Medicare does not expect to see E/M services billed routinely on the same day as HBO treatment. Medical necessity and work of a separately identifiable significant concurrent E/M services must be documented when reported for Medicare payment. Generally, the contractor will expect to find the E/M service reported only in the case of medically necessary E/M work related to a separate issue (unrelated to the wound) or a complication of HBO or the underlying medical condition for which HBO is required. Routine wound assessment, wound monitoring, and redressing of the wound, in addition to an assessment of the patient, cardiopulmonary stability and general clinical condition prior to the initiation of the therapy is an integral part of the HBO treatment and all are included in payment for physician supervision of HBO services (99183).

Licensed Professional Training and Competency Requirements:

- All physicians (MD, DO, DPM) who administer and/or supervise HBOT must maintain current Advanced Cardiac Life Support certification by the American Heart Association.
  - Completion (within the prior 2 years) of a 40-hour in-person or web-based accredited training program approved by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society.
  - Certification by one of the following:
    - Undersea and Hyperbaric Medicine by the American Board of Emergency Medicine (ABEM) or American Board of Preventive Medicine (ABPM) or the American Osteopathic Conjoint Committee of Undersea and Hyperbaric Medicine (AOCUHM);
    - Physician Certification in Hyperbaric Medicine as endorsed by The American College of Hyperbaric Medicine (Certificate of Added Qualification – The American Board of Wound Healing);
    - Completion of a minimum of 25 hyperbaric patient treatments proctored in person either by a physician credentialed in hyperbaric medicine at the institution or who meets the requirements in this LCD.
  - Podiatric Physicians may administer and/or supervise HBOT only when HBOT is within their State Scope of Practice and the body area or condition being treated with HBOT is also within the podiatric scope of practice.

HBOT Facility Requirements:

These requirements are intended to ensure that clinical hyperbaric facilities are properly equipped and staffed to operated with the highest level possible of patient safety and care.

- Standards for facility operation are ensured by the development of hyperbaric facility operational policies and procedures that comply with and adhere to standards and guidelines have been issued by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the National Fire Protection Association (NFPA) (NFPA 99, Health Care Facilities, Chapter 20, Hyperbaric Facilities, 2005 Edition) the Accreditation Association for Ambulatory Health Care (AAAHC), the Compressed Gas Association (CGA), and the American Institute of Architects (AIA) (Guidelines for Design and
Construction of Health Care Facilities publication – Hyperbaric Appendix). Facility policies should be developed and maintained in major areas related to hyperbaric operations to include: Administration, Risk Management and Quality; Facility Construction, Operations and Maintenance; and Chamber Fabrication, Ventilation and Gas Handling, Electrical Systems and Fire Protection.

- It is required that facilities receive an Accreditation Survey by the Undersea & Hyperbaric Medical Society
- It is required that each facility designate a Hyperbaric Safety Director to monitor all hyperbaric facility equipment and to implement the operational safety requirements as required by NFPA Code.

Facility Staff Training and Competency Requirements

Nursing and technical staff who administer hyperbaric patient care services in facilities must obtain the following training and certifications:

- ACLS certification
- Completion of a minimum of a 40-hour in-person or web-based accredited training program such as one approved by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society.
- Certification in Hyperbaric Medicine by one of the following:
  - The American Board of Wound Healing (ABWH),
  - The Baromedical Nurses Association (BNA),
  - The National Board of Diving & Hyperbaric Medical Technology (NBDHMT).

Supervision of HBOT

Hyperbaric Oxygen Therapy (HBOT) requires Direct Physician Supervision. Direct Supervision is achieved when a physician is Immediately Available during the entire hyperbaric treatment session. The physician’s personal presence is required during the ascent and descent portions of the hyperbaric treatment.

- The Office of the Inspector General (OIG) links the quality of care to the physical presence of the physician (Qualified Hyperbaric Health Care Professional ) during the entire treatment for the purpose of managing the patient’s overall care, as identified in the October 2000 report, ‘Hyperbaric Oxygen Therapy, Its Use and Appropriateness.’
- In the hospital outpatient setting, “direct supervision” per 42 CFR 410.27(f) means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure.
- For non-hospital settings, the physician must be present in the office or office suite.
- Immediately Available: The Qualified Hyperbaric Health Care Professional must be Immediately Available when HBOT is administered. When HBOT is administered in a hospital setting, the QHHCP is considered to be Immediately Available when the maximum response time required to be physically present at the chamber is less than five minutes. The hospital premises are defined as either an on-campus provider-based department or a qualified off-campus site (certified as part of the hospital or hospital campus). The five minute response time interval begins upon initiation of the request, not upon receipt by the QHHCP.

Proposed/Draft Process Information
**Associated Information**

**Documentation Requirements**

Facilities must maintain accurate documentation of all staff and supervising physician training and competency records.

Documentation supporting medical necessity should be legible, maintained in the patient’s medical record and made available to Medicare upon request.

The documentation present in the clinical record must provide an accurate description and diagnosis of the medical condition supporting that the use of HBO is reasonable and medically necessary. The medical documentation must include but is not limited to the following:

- An initial assessment, which includes a history and physical that clearly substantiates the condition for which HBO is recommended. This should also include any prior medical, surgical and/or HBO treatments.

- Documentation of the procedure (logs) including ascent time, descent time and pressurization level. There should be a treatment plan identifying timeline and treatment goals.

- Physician-to-physician communications or records of consultations and/or additional assessments, recommendations or procedural reports.

- Laboratory reports (cultures or Gram stains) that confirm the diagnosis of necrotizing fasciitis are required and must be present as support for payment of HBO.

- X-ray findings and bone cultures confirming the diagnosis of osteomyelitis are required and must be present as support for payment of HBO.

- Documentation to support the presence of gas gangrene as proven with laboratory reports (Gram stain or cultures) and X-ray.

- Physicians’ progress notes that describe the physical findings, type(s) of treatment(s) provided, number of treatments provided, the effect of treatment(s) received and the assessment of the level of progress made toward achieving the completion of established therapy goals.

- Documentation of date and anatomical site of prior radiation treatments.

- Documentation supporting date of skin graft and compromised state of graft site.

- No payment will be allowed for HBO without documentation that a trained emergency response team is available and that the setting provides the required availability of ICU services that could be needed to ensure the patient’s safety if a complication occurred.

- For diabetic wounds of the lower extremity, the Wagner classification of the wound and the failure of an adequate course (at least 30 days) of standard wound therapy must be documented at the initiation of therapy:

  - Documentation must demonstrate an ulcer with bone involvement (osteomyelitis), localized gangrene or gangrene of the whole foot.

  - Documentation of standard wound care in patients with diabetic wounds must include: assessment of a patient’s vascular status and documentation of correction of any vascular problems in the affected limb; documentation of optimization of nutritional status; documentation of optimization of glucose control; documentation of debridement by any means to remove devitalized tissue; documentation of maintenance of a clean, moist bed of granulation tissue with
appropriate moist dressings; documentation of efforts for appropriate off-loading; and documentation of necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there is no documentation of measurable signs of healing for at least 30 consecutive days. The medical record must include, at a minimum, a wound evaluation at least every 30 days during administration of HBO therapy.

**Utilization Guidelines**

HBO therapy should not be a replacement for other standard successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than one week to several months duration, the average being two to four weeks.

Review and document the medical necessity for the use of hyperbaric oxygen for more than two months, regardless of the condition of the patient.

**Notice:** This LCD imposes utilization guideline limitations. Despite Medicare's allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

**Sources of Information and Basis for Decision**

*Contractor is not responsible for the continued viability of websites listed.*


**Other Contractor Policies**

**Contractor Medical Directors**

**Carrier Advisory Committee (CAC) Meetings**

N/A
Comment Period Start Date
01/16/2014

Comment Period End Date
03/06/2014

Released to Final LCD Date
Not yet released.

Reason for Proposed LCD
Creation of Uniform LCDs With Other MAC Jurisdiction

Coding Information

[PROPOSED/DRAFT]

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>013x</td>
<td>Hospital Outpatient</td>
</tr>
<tr>
<td>085x</td>
<td>Critical Access Hospital</td>
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</table>

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Note: The contractor has identified the Bill Type and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes. Providers are encouraged to refer to the CMS Internet-Only Manual (IOM) Pub. 100-04, Claims Processing Manual, for further guidance.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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CPT/HCPCS Codes

Group 1 Paragraph: Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT books. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

Group 1 Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>99183</td>
<td>Hyperbaric oxygen therapy</td>
</tr>
<tr>
<td>C1300</td>
<td>HYPERBARIC Oxygen</td>
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</table>

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph: Note: Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

The CPT/HCPCS codes included in this LCD will be subjected to procedure to diagnosis editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for CPT/HCPCS codes C1300 and 99183:

Group 1 Codes:

<table>
<thead>
<tr>
<th>Code</th>
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<tr>
<td>039.0 - 039.4</td>
<td>CUTANEOUS ACTINOMYCOTIC INFECTION - MADURA FOOT</td>
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<tr>
<td>039.8 - 039.9</td>
<td>ACTINOMYCOTIC INFECTION OF OTHER SPECIFIED SITES - ACTINOMYCOTIC INFECTION OF UNSPECIFIED SITE</td>
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<tr>
<td>040.0</td>
<td>GAS GANGRENE</td>
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<td>250.70 - 250.73*</td>
<td>DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE I [JUVENILE TYPE], UNCONTROLLED</td>
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<td>250.80 - 250.83*</td>
<td>DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED</td>
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<td>444.21 - 444.22*</td>
<td>ARTERIAL EMBOLISM AND THROMBOSIS OF UPPER EXTREMITY - ARTERIAL EMBOLISM AND THROMBOSIS OF LOWER EXTREMITY</td>
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<td>444.81*</td>
<td>EMBOLISM AND THROMBOSIS OF ILIAC ARTERY</td>
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<td>526.89</td>
<td>OTHER SPECIFIED DISEASES OF THE JAWS</td>
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<td>707.10 - 707.15*</td>
<td>UNSPECIFIED ULCER OF LOWER LIMB - ULCER OF OTHER PART OF FOOT</td>
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<td>707.19*</td>
<td>ULCER OF OTHER PART OF LOWER LIMB</td>
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<tr>
<td>728.86*</td>
<td>NECROTIZING FASCIITIS</td>
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<td>CHRONIC OSTEOMYELITIS SITE UNSPECIFIED - CHRONIC OSTEOMYELITIS INVOLVING MULTIPLE SITES</td>
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<td>904.0*</td>
<td>INJURY TO COMMON FEMORAL ARTERY</td>
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<td>904.41*</td>
<td>INJURY TO POPLITEAL ARTERY</td>
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<tr>
<td>909.2*</td>
<td>LATE EFFECT OF RADIATION</td>
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<tr>
<td>927.00 - 927.03*</td>
<td>CRUSHING INJURY OF SHOULDER REGION - CRUSHING INJURY OF UPPER ARM</td>
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<tr>
<td>927.09*</td>
<td>CRUSHING INJURY OF MULTIPLE SITES OF UPPER ARM</td>
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<tr>
<td>927.10 - 927.11*</td>
<td>CRUSHING INJURY OF FOREARM - CRUSHING INJURY OF ELBOW</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>927.20 -</td>
<td>CRUSHING INJURY OF HAND(S) - CRUSHING INJURY OF WRIST</td>
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<td>927.21*</td>
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<td>927.8 -</td>
<td>CRUSHING INJURY OF MULTIPLE SITES OF UPPER LIMB - CRUSHING INJURY OF UNSPECIFIED SITE OF UPPER LIMB</td>
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<td>928.00 -</td>
<td>CRUSHING INJURY OF THIGH - CRUSHING INJURY OF HIP</td>
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<td>928.01*</td>
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<td>928.10 -</td>
<td>CRUSHING INJURY OF LOWER LEG - CRUSHING INJURY OF KNEE</td>
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<tr>
<td>928.20 -</td>
<td>CRUSHING INJURY OF FOOT - CRUSHING INJURY OF ANKLE</td>
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<td>928.21*</td>
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<td>928.3*</td>
<td>CRUSHING INJURY OF TOE(S)</td>
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<td>928.8 -</td>
<td>CRUSHING INJURY OF MULTIPLE SITES OF LOWER LIMB - CRUSHING INJURY OF UNSPECIFIED SITE OF LOWER LIMB</td>
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<td>929.0*</td>
<td>CRUSHING INJURY OF MULTIPLE SITES NOT ELSEWHERE CLASSIFIED</td>
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<td>929.9*</td>
<td>CRUSHING INJURY OF UNSPECIFIED SITE</td>
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<td>958.0*</td>
<td>AIR EMBOLISM AS AN EARLY COMPLICATION OF TRAUMA</td>
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<tr>
<td>986*</td>
<td>TOXIC EFFECT OF CARBON MONOXIDE</td>
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<td>987.7*</td>
<td>TOXIC EFFECT OF HYDROCYANIC ACID GAS</td>
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<td>989.0*</td>
<td>TOXIC EFFECT OF HYDROCYANIC ACID AND CYANIDES</td>
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<td>990*</td>
<td>EFFECTS OF RADIATION UNSPECIFIED</td>
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<td>993.2 -</td>
<td>OTHER AND UNSPECIFIED EFFECTS OF HIGH ALTITUDE - CAISSON DISEASE</td>
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<tr>
<td>996.52</td>
<td>MECHANICAL COMPLICATION OF PROSTHETIC GRAFT OF OTHER TISSUE NOT ELSEWHERE CLASSIFIED</td>
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<tr>
<td>996.90 -</td>
<td>COMPLICATIONS OF UNSPECIFIED REATTACHED EXTREMITY - COMPLICATION OF REATTACHED LOWER EXTREMITY OTHER AND UNSPECIFIED</td>
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<td>996.96*</td>
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Group 1 Asterisk: ICD-9-CM codes 250.70–250.73 or 250.80–250.83 must be listed in addition to a covered wound diagnosis code (707.10–707.15 or 707.19) to indicate this condition. Per NCD 20.29.

Codes 444.21 - 444.22, 444.81, 728.86, 902.53, 903.01, 903.1, 904.0, 904.41, 927.00 - 927.03, 927.09, 927.10 - 927.11, 927.20 - 927.21, 927.8 - 927.9, 928.00 - 928.01, 928.10 - 928.11, 928.20 - 928.21, 928.3, 928.8 - 928.9, 929.0, 929.9, 958.0, 986, 987.7, 989.0, 996.90 - 996.96, 996.99 & 999.1 are covered only when provided in the inpatient setting.

Code (909.2) also the condition or nature of the late effect, which should be sequenced first.

Code (990) also the specific diagnosis code(s) for the condition or nature of the effect of radiation, if known based on medical record documentation; this code (or codes) should be sequenced first.

ICD-9 Codes that DO NOT Support Medical Necessity

All diagnoses not listed in the “ICD-9-CM Codes That Support Medical Necessity” section of this LCD.

Associated Documents

Attachments

There are no attachments for this LCD

Related Local Coverage Documents

This LCD has no Related Documents.

Related National Coverage Documents

This LCD version has no Related National Coverage Documents.

[PROPOSED/DRAFT]

Keywords

N/A