I. Policy: Topical Oxygenation

II. Purpose/Objective:
   To provide a policy of coverage regarding Topical Oxygenation

III. Responsibility:
   A. Medical Directors
   B. Medical Management

IV. Required Definitions
   1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
   2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
   3. Devised – the date the policy was implemented.
   4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
   5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

   a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
   b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
   c. in accordance with current standards of good medical treatment practiced by the general medical community.
   d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
   e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

   (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
   (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
   (iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Topical oxygenation, also referred to as topical hyperbaric oxygenation, is the use of 100% oxygen applied at just above atmospheric pressure to moist open wounds. The theory behind this therapy is that the increase in oxygen at the surface of the wound speeds healing. Unlike hyperbaric oxygen therapy (addressed in MP47) which involves whole-body pressurization and inhalation of 100% oxygen at a minimum of 1.4 (usually 1.4-2.5) atmospheres, topical oxygenation is delivered via a specially constructed chamber that fits around a limb or by using disposable polyethylene bags that surrounds the wound area, and oxygen is delivered under pressure from a source that may be a conventional oxygen tank. Examples of topical Hyperbaric Oxygen Therapy (HBOT) devices include but are not limited to TOPOX portable hyperbaric oxygen extremity and sacral chambers, Oxyboot and Oxyhealer from GWR Medical, L.L.P.

EXCLUSIONS:
The current body of evidence in the peer-reviewed, published medical literature supporting the use of topical oxygenation for any indication is insufficient to allow adequate conclusions regarding efficacy. The Plan does NOT provide coverage for topical oxygenation because it is considered experimental, investigational or unproven.

For information on full body hyperbaric oxygen therapy please refer to MP 47 Hyperbaric Oxygen Therapy.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Topical Oxygenation
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

A4575  Topical hyperbaric oxygen chamber, disposable
E0446  Topical oxygen delivery system, not otherwise specified, includes all supplies.


LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

Undersea and Hyperbaric Medicine Society. Indications for Hyperbaric Oxygen Therapy.

ECRI Institute, HTAIS Custom Hotline Service. Topical Oxygen therapy for Chronic Wound Healing.


Novitas Solutions Inc. Medicare Local Coverage Determination (LCD). L35021 Hyperbaric Oxygen (HBO) Therapy


This policy will be revised as necessary and reviewed no less than annually.

Devised: 12/03/08

Revised:

Reviewed: 1/10, 12/10 (coding), 12/11, 12/12, 12/13, 12/14, 12/15, 12/16, 11/17, 11/18