Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service Insurance Corporation

Contractor Number
00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302, 05402, 52280

Title
Billing and Coding Guidelines for Hyperbaric Oxygen (HBO) Therapy

Original Effective Date
06/15/2011

Revision Effective Date

Excerpt from Internet Only Manual: Pub. 100-3, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, §20.29, Hyperbaric Oxygen Therapy

Description:
For purposes of coverage under Medicare, hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

A. Covered Conditions

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one man unit) and is limited to the following conditions:

1. Acute carbon monoxide intoxication
2. Decompression illness
3. Gas embolism
4. Gas gangrene
5. Acute traumatic peripheral ischemia. 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.
6. Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened.
7. Progressive necrotizing infections (necrotizing fasciitis)
8. Acute peripheral arterial insufficiency
9. Preparation and preservation of compromised skin grafts (not for primary management of wounds)
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management,
11. Osteoradionecrosis as an adjunct to conventional treatment
12. Soft tissue radionecrosis as an adjunct to conventional treatment
13. Cyanide poisoning,
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
15. Diabetic wounds of the lower extremities in patients who meet the following three criteria:

a. Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes

b. Patient has a wound classified as Wagner grade III or higher, and

c. Patient has failed an adequate course of standard treatment.

The use of HBO therapy is covered as adjunctive therapy only after there are no measureable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in patients with diabetic wounds includes; assessment of a patient's vascular status and correction of vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there is no measureable signs of healing for at least 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered f measureable signs of healing have not been demonstrated within any 30-day period of treatment.

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B. Noncovered Conditions

All other indications not specified under §270.4(A) are not covered under the Medicare program. No program payment may be made for any conditions other than those listed in §270.4(A). No program payment may be made for HBO in the treatment of the following conditions:

1. Cutaneous, decubitus, and stasis ulcers.

2. Chronic peripheral vascular insufficiency.

3. Anaerobic septicemia and infection other than clostridial.

4. Skin burns (thermal).

5. Senility.

6. Myocardial infarction.

7. Cardiogenic shock.

8. Sickle cell anemia.

9. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary.

10. Acute or chronic cerebral vascular insufficiency.

11. Hepatic necrosis.

12. Aerobic septicemia.

13. Nonvascular causes of chronic brain disease. (Pick's disease, Alzheimer's disease, Korsakoff's disease).

14. Tetanus

15. Systemic aerobic infection.

16. Organ transplantation.

17. Organ storage.

18. Pulmonary emphysema.

19. Exceptional blood loss anemia.

20. Multiple Sclerosis.

21. Arthritic Diseases.

22. Acute cerebraledema.

C. Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy as stated above. ("Above" refers to section B, noncovered conditions). Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen. Cross reference: §270.5 of this manual.

Coding Guidelines

I. General

1. CPT Code 99183 describes the physician work (presence and supervision) involved in this service. Documentation should support this.
2. Use CPT-4 code 99183 to describe both the initial and the subsequent treatments.
3. *If the therapy is continued for more than two months, documentation of medical necessity must accompany the claim and it will be reviewed on a case-by-case basis.*
4. CPT code 99183 applies to Non-Outpatient Prospective Payment System (Non-OPPS) providers only.
5. HPPS code C1300 applies to Part A OPPS providers only.
6. Claims for HBO of the treatment of diabetic wounds of the lower extremity require documentation of dual diagnoses. An ICD-9-CM code from either the 250.70-250.73 range or the 250.80-250.83 range (representing a diabetes-related problem) plus one of the following ICD-9-CM codes: 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, or 707.19 (representing a lower extremity wound) must be reported. Claims for diabetic wounds without dual diagnoses do not meet utilization guidelines described in this coding and billing document and will be considered medically unnecessary and will be denied.
7. Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.
8. Title XVIII of the Social Security Act, section 1862(a)(1)(A) only allows coverage and payment for those services that are considered to be medically reasonable and necessary. Thus, chest x-rays, routine laboratory tests, routing EKGs, routine specialty consultations, other screening tests, or other testing driven by protocol are not covered.
9. Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

II. For claims submitted to the fiscal intermediary or MAC Part A:

Claims for HBO therapy should be submitted on Form CMS-1450 or its electronic equivalent.

Note: *Code C1300 is not available for use other than in a hospital outpatient department. In skilled nursing facilities (SNFs), HBO therapy is part of the SNF PPS payment for beneficiaries in covered Part A stays.*

For hospital inpatients and critical access hospitals (CAHs) not electing Method I, HBO therapy is reported under revenue code 940 without any HCPCS code. For inpatient services, show ICD-9-CM procedure code 93.59.

For CAHs electing Method I, HBO therapy is reported under revenue code 940 along with HCPCS code 99183.

The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. The principal diagnosis is the condition established to be the primary reason for this admission.

III. For claims submitted to the carrier or MAC Part B:

Claims for this service should be submitted on Form CMS-1500 or its electronic equivalent.

The following HCPCS code applies:

- *99183 – Physician attendance and supervision of hyperbaric oxygen therapy, per session.*

Claims for CPT code 99183 are **billable** under Medicare Part B in the following places of service: office (11), inpatient hospital (21), hospital outpatient hospital (22) and independent clinic (49). However, place of service office (11) is unlikely. Therefore, CPT code 99183 when billed in POS office (11) will suspend for medical review.

According to CPT coding guidelines, Evaluation and Management services and/or procedures (e.g. wound debridement) provided in a hyperbaric oxygen treatment facility in conjunction with a hyperbaric oxygen therapy session should be reported separately.

ICD-9-CM codes 040.0, 444.21, 444.22, 444.81, 728.86 and 999.1 represent critically ill patients. Claims for CPT code 99183 with one of these diagnoses when billed for services in any place of service other than inpatient hospital (21), will be denied as medically unnecessary. .

Sources of Information:
Pub. 100-3, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, §20.29, Hyperbaric Oxygen Therapy

Revision History/Explanation:
Italicized font – represents CMS national policy language/wording copied directly from CMS

Manuals or CMS Transmittals. Contractors are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process.

NCDs are binding on all carriers, fiscal intermediaries, MAC Contractors, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on Medicare Advantage Organizations. In addition, an administrative law judge may not review an NCD. (See §1869(f)(1)(A)(i) of the Social Security Act.)