| **Patient Name:** | | | | | **Reference #:** |
| --- | --- | --- | --- | --- | --- |
| **Policy Title:** | | **Hyperbaric Oxygen Pressurization (HBO)** | | | |
| **Effective Date:** | | **January 30, 2015** | | | |
| **MD Determination:** | | | APPROVE  DENY  MODIFY | | |
| **NOT MEDICALLY NECESSARY**  LEGACY (EOB A118) – FACETS (AJW-claim, JLP-line) | | | | | |
|  | **PRINCIPAL REASON:**  A Blue Shield of California Medical Director has reviewed the submitted medical documentation and determined the service is not medically necessary as established in the Blue Shield of California Medical Policy. | | | | |
|  | **CLINICAL RATIONALE**:  The requested service, **Systemic hyperbaric oxygen pressurization**, may be considered **medically necessary** in the treatment of **any** of the following conditions:   * Acute carbon monoxide poisoning * Acute cyanide poisoning * Acute gas embolism * Acute traumatic ischemia (e.g., crush injuries, reperfusion injury, compartment syndrome * Chronic refractory osteomyelitis * Decompression sickness * Gas gangrene (i.e., clostridial myonecrosis) * Non-healing diabetic wounds of the lower extremities in patients who meet **all** of the following criteria: * 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 3 or higher (see Policy Guidelines) * Patient has no measurable signs of healing after 30 days of an adequate course of standard wound therapy * Pre- and post-treatment for patients undergoing dental surgery (non-implant related) of an irradiated jaw * Profound anemia with exceptional blood loss: only when blood transfusion is impossible or must be delayed * Soft-tissue radiation necrosis (e.g., radiation enteritis, cystitis, proctitis) and osteoradionecrosis   The medical records do NOT show that you have met **any** of the above conditions. Therefore, the requested service has been determined to be not medically necessary. | | | | |
|  | Additional comments: | | | | |
|  | The following documentation has not been submitted: | | | | |
| **INVESTIGATIONAL/EXPERIMENTAL**  LEGACY (EOB A232) – FACETS (AJK-claim, JHR-line) | | | | | |
|  | **PRINCIPAL REASON:**  A Blue Shield of California Medical Director has determined that the service or item is identified in Blue Shield of California Medical Policy as investigational or experimental and therefore, is not covered. | | | | |
|  | **CLINICAL RATIONALE**:  Topical hyperbaric oxygen therapy is considered **investigational**. The clinical benefit and/or safety of this service over standard evaluation and/or treatment have not been established in the published scientific peer-reviewed literature. There is insufficient evidence in the peer- reviewed literature regarding its effect on improving health outcomes. Therefore, the requested service has been determined to be investigational or experimental and thus, not covered. Your plan does provide for standard treatment and services. | | | | |
|  | Additional comments: | | | | |
|  | **CLINICAL RATIONALE**:  The use of **Hyperbaric oxygen pressurization** is considered **investigational** for all other indications outside of the medical necessity criteria, including but not limited to, the treatment of the following conditions:   * Acute carbon tetrachloride poisoning * Acute cerebral edema * Acute coronary syndromes and as an adjunct to coronary interventions, including but not limited to, percutaneous coronary interventions and cardiopulmonary bypass * Acute ischemic stroke * Acute osteomyelitis * Acute peripheral arterial insufficiency * Acute retinal artery insufficiency * Acute surgical and traumatic wounds * Acute thermal burns * Autism spectrum disorders * Bell's palsy * Bisphosphonate-related osteonecrosis of the jaw * Bone grafts * Brown recluse spider bites * Cerebral palsy * Cerebrovascular disease, acute (thrombotic or embolic) or chronic * Chronic arm lymphedema following radiotherapy for cancer * Chronic wounds, other than those in patients with diabetes who meet the criteria specified in the medically necessary statement * Compromised skin grafts or flaps * Delayed onset muscle soreness * Demyelinating diseases (e.g., multiple sclerosis, amyotrophic lateral sclerosis) * Early treatment (beginning at completion of radiotherapy) to reduce adverse effects of radiotherapy * Fracture healing * Herpes zoster * Hydrogen sulfide poisoning * Idiopathic femoral neck necrosis * Idiopathic sudden sensorineural hearing loss (ISSNHL) * In vitro fertilization * Inflammatory bowel disease (Crohn’s disease or ulcerative colitis) * Intra-abdominal and intracranial abscesses * Lepromatous leprosy * Meningitis * Migraine * Motor dysfunction associated with stroke * Necrotizing soft tissue infections * Pseudomembranous colitis (antimicrobial agent-induced colitis) * Pyoderma gangrenosum * Radiation-induced injury in the head and neck * Radiation myelitis * Radiation-induced injury in the head and neck, except as noted earlier in the medically necessary statement * Refractory mycoses: mucormycosis, actinomycosis, conidiobolus coronato * Retinopathy, adjunct to scleral buckling procedures in patients with sickle cell peripheral retinopathy and retinal detachment * Senility related disorders including dementia, vascular dementia, and cognitive impairment * Sickle cell crisis and/or hematuria * Spinal cord injury * Traumatic brain injury * Tumor sensitization for cancer treatments, including but not limited to, radiotherapy or chemotherapy   The medical records show that the service requested is one of the above indications or outside of the medical necessity criteria. The clinical benefit and/or safety of this service over standard evaluation and/or treatment have not been established in the published scientific peer-reviewed literature. There is insufficient evidence in the peer- reviewed literature regarding its effect on improving health outcomes. Therefore, the requested service has been determined to be investigational or experimental and thus, not covered. Your plan does provide for standard treatment and services. | | | | |
|  | Additional comments: | | | | |
| **NOT A COVERED BENEFIT**  LEGACY (EOB A511) – FACETS (AJQ-claim, JII-line) | | | | | |
|  | **PRINCIPAL REASON:**  A Blue Shield of California Medical Director has reviewed the submitted medical documentation and has determined the service is not a covered benefit per your Evidence of Coverage (EOC).  EOC Provision Page Number:  EOC Provision Language:       **COMMENTS**: | | | | |
| **OTHER**  LEGACY (EOB A118) – FACETS (AJW-claim, JLP-line) | | | | | |
|  | **(Explanation):** | | | | |
| **Physician Advisor’s Signature:** | | | |  | |