



FEP Medical Policy Manual

FEP 2.01.04 Hyperbaric Oxygen Therapy

Effective Policy Date: April 1, 2022

Original Policy Date: September 2012

Related Policies:

None

Hyperbaric Oxygen Therapy

Description

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Hyperbaric oxygen therapy (HBOT) involves breathing 100% oxygen at pressures between 1.5 and 3.0 atmospheres. It is generally applied systemically with the patient inside a hyperbaric chamber. HBOT can also be applied topically; ie, the body part to be treated is isolated (eg, in an inflatable bag and exposed to pure oxygen). HBOT has been investigated for various conditions that have potential to respond to increased oxygen delivery to tissue.

OBJECTIVE

The objective of this evidence review is to determine whether the use of systemic hyperbaric oxygen pressurization improves net health outcomes for a variety of indications.

POLICY STATEMENT

Systemic hyperbaric oxygen pressurization may be considered **medically necessary** in the treatment of the following conditions:

- nonhealing diabetic wounds of the lower extremities in patients who meet the following 3 criteria:
 - Patient has type 1 or type 2 diabetes and has a lower-extremity wound due to diabetes;
 - Patient has a wound classified as Wagner grade 3 or higher (see Policy Guidelines section); and
 - Patient has no measurable signs of healing after 30 days of an adequate course of standard wound therapy;
- acute traumatic ischemia (eg, crush injuries, reperfusion injury, compartment syndrome);
- decompression sickness;
- gas embolism, acute;
- cyanide poisoning, acute;
- acute carbon monoxide poisoning;
- soft-tissue radiation necrosis (eg, radiation enteritis, cystitis, proctitis) and osteoradionecrosis;
- pre- and posttreatment for patients undergoing dental surgery (non-implant-related) of an irradiated jaw;
- gas gangrene (ie, clostridial myonecrosis);
- profound anemia with exceptional blood loss: only when blood transfusion is impossible or must be delayed; and
- chronic refractory osteomyelitis.

Hyperbaric oxygen pressurization is considered **investigational** in all other situations, including but not limited to, the treatment of the following conditions:

- compromised skin grafts or flaps;
- acute osteomyelitis;
- bisphosphonate-related osteonecrosis of the jaw;
- necrotizing soft tissue infections;
- acute thermal burns;
- acute surgical and traumatic wounds;
- chronic wounds, other than those in patients with diabetes who meet the criteria specified in the medically necessary statement;
- spinal cord injury;
- traumatic brain injury;
- inflammatory bowel disease (Crohn disease or ulcerative colitis);
- brown recluse spider bites;
- bone grafts;
- carbon tetrachloride poisoning, acute;
- cerebrovascular disease, acute (thrombotic or embolic) or chronic;
- fracture healing;

- hydrogen sulfide poisoning;
- intra-abdominal and intracranial abscesses;
- lepromatous leprosy;
- meningitis;
- pseudomembranous colitis (antimicrobial agent-induced colitis);
- radiation myelitis;
- sickle cell crisis and/or hematuria;
- demyelinating diseases (eg, multiple sclerosis, amyotrophic lateral sclerosis);
- retinal artery insufficiency, acute;
- retinopathy, adjunct to scleral buckling procedures in patients with sickle cell peripheral retinopathy and retinal detachment;
- pyoderma gangrenosum;
- acute arterial peripheral insufficiency;
- acute coronary syndromes and as an adjunct to coronary interventions, including but not limited to, percutaneous coronary interventions and cardiopulmonary bypass;
- idiopathic sudden sensorineural hearing loss;
- refractory mycoses: mucormycosis, actinomycosis, conidiobolus coronato;
- cerebral edema, acute;
- migraine;
- in vitro fertilization;
- cerebral palsy;
- tumor sensitization for cancer treatments, including but not limited to, radiotherapy or chemotherapy;
- delayed-onset muscle soreness;
- idiopathic femoral neck necrosis;
- chronic arm lymphedema following radiotherapy for cancer;
- radiation-induced injury in the head and neck, except as noted earlier in the medically necessary statement;
- early treatment (beginning at completion of radiotherapy) to reduce adverse events of radiotherapy;
- autism spectrum disorder;
- Bell palsy;
- acute ischemic stroke;
- motor dysfunction associated with stroke;
- herpes zoster;
- vascular dementia;
- fibromyalgia; and
- mental illness (ie, posttraumatic stress disorder, generalized anxiety disorder or depression).

POLICY GUIDELINES

Systemic Hyperbaric Oxygen

The Wagner classification system categorizes wounds as follows: grade 0, no open lesion; grade 1, superficial ulcer without penetration to deeper layers; grade 2, ulcer penetrates to tendon, bone, or joint; grade 3, lesion has penetrated deeper than grade 2, and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths; grade 4, wet or dry gangrene in the toes or forefoot; grade 5, gangrene involves the whole foot or such a percentage that no local procedures are possible and amputation (at least at the below the knee level) is indicated.

Following are recommended indications from the Undersea and Hyperbaric Medical Society's (UHMS) 2019 Hyperbaric Oxygen Therapy Committee report on utilization of HBOT (14th edition):

- Air or gas embolism
- Carbon monoxide poisoning and carbon monoxide complicated by cyanide poisoning
- Clostridial myositis and myonecrosis (gas gangrene)
- Crush injury, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Central retinal artery occlusion
- Diabetic foot ulcer
- Healing of other problem wounds
- Severe anemia
- Intracranial abscess
- Necrotizing soft tissue infections
- Refractory osteomyelitis
- Delayed radiation injury (soft tissue and bony necrosis)
- Compromised grafts and flaps
- Acute thermal burn injury
- Sudden sensorineural hearing loss.

BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

FDA REGULATORY STATUS

Since 1979, the U.S. Food and Drug Administration (FDA) has cleared multiple topical and systemic hyperbaric oxygen administration devices through the 510(k) pathway. In 2013, the FDA published a statement warning that non-FDA approved uses of HBOT may endanger the health of patients.² If patients mistakenly believe that HBOT devices have been proven safe for uses not cleared by the FDA, they may delay or forgo proven medical therapies.

RATIONALE

Summary of Evidence

For individuals with chronic diabetic ulcers who receive systemic hyperbaric oxygen therapy (HBOT), the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms and change in disease status. Meta-analyses of RCTs found significantly higher diabetic ulcer healing rates with HBOT than with control conditions. One of the 2 meta-analyses found that HBOT was associated with a significantly lower rate of major amputation. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with carbon monoxide poisoning who receive systemic HBOT, the evidence includes RCTs and a systematic review. Relevant outcomes are overall survival (OS) and symptoms. A meta-analysis in a Cochrane review of low-quality RCT data did not find HBOT to be associated with a significantly lower risk of neurologic deficits after carbon monoxide poisoning. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with radionecrosis, osteoradionecrosis, or treatment of irradiated jaw who receive systemic HBOT, the evidence includes RCTs and a systematic review. Relevant outcomes are symptoms and change in disease status. A meta-analysis in a Cochrane review of RCTs found evidence that HBOT improved radionecrosis and osteoradionecrosis outcomes and resulted in better outcomes before tooth extraction in an irradiated jaw. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with chronic refractory osteomyelitis who receive systemic HBOT, the evidence includes case series. Relevant outcomes are symptoms and change in disease status. The case series reported high rates of successful outcomes (no drainage, pain, tenderness, or cellulitis) in patients with chronic refractory osteomyelitis treated with HBOT. However, controlled studies are needed to determine conclusively the impact of HBOT on health outcomes compared with other interventions. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with acute thermal burns who receive systemic HBOT, the evidence includes a systematic review of 2 RCTs. Relevant outcomes are overall survival (OS), symptoms, and change in disease status. Both RCTs were judged to have poor methodologic quality. Evidence from well-conducted controlled trials is needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with acute surgical and traumatic wounds who receive systemic HBOT, the evidence includes RCTs, controlled nonrandomized studies, and systematic reviews. Relevant outcomes are OS, symptoms, change in disease status, and functional outcomes. There was considerable heterogeneity across the 4 RCTs identified (eg, patient population, comparison group, treatment regimen, outcomes). This heterogeneity prevented pooling of trial findings and limits the ability to conclude the impact of HBOT on health outcomes for patients with acute surgical and traumatic wounds. Additional evidence from high-quality RCTs is needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with bisphosphonate-related osteonecrosis of the jaw who receive systemic HBOT, the evidence includes an randomized controlled trial (RCT). Relevant outcomes are symptoms and change in disease status. The RCT was unblinded and reported initial benefits at 3-month follow-up; however, there were no significant benefits of HBOT for most health outcomes compared with standard care in the long-term (6 months to 2 years). The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with necrotizing soft tissue infections who receive systemic HBOT, the evidence includes systematic reviews and a retrospective cohort study. Relevant outcomes are OS, symptoms, and change in disease status. A Cochrane review did not identify any RCTs. Another systematic review identified a retrospective cohort study, which did not find better outcomes after HBOT than after standard care without HBOT in patients with necrotizing soft tissue infections. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with acute coronary syndrome who receive systemic HBOT, the evidence includes RCTs and a systematic review. Relevant outcomes are OS, symptoms, change in disease status, and functional outcomes. A Cochrane review identified 6 RCTs. There were 2 pooled analyses, 1 found significantly lower rates of death with HBOT and the other reported inconsistent results in left ventricular function. Additional RCT data are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with acute ischemic stroke who receive systemic HBOT, the evidence includes RCTs and a systematic review. Relevant outcomes are OS, symptoms, change in disease status, and functional outcomes. Cochrane reviewers could only pool data for a single outcome (mortality at 3-6 months), and for that outcome, there was no significant difference between active and sham HBOT treatments. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with motor dysfunction associated with stroke who receive systemic HBOT, the evidence includes an RCT. Relevant outcomes are symptoms and functional outcomes. The RCT, which used a crossover design, found better outcomes with HBOT at 2 months than with delayed treatment. However, the trial had a number of methodologic limitations (eg, lack of patient blinding, heterogeneous population, high dropout rate) that

make it difficult to evaluate the efficacy of HBOT. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with Bell palsy who receive systemic HBOT, the evidence includes a systematic review. Relevant outcomes are symptoms, change in disease status, and functional outcomes. A Cochrane review did not identify any RCTs meeting selection criteria; the single RCT found did not have a blinded outcome assessment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with traumatic brain injury who receive systemic HBOT, the evidence includes RCTs and systematic reviews. Relevant outcomes are OS, symptoms, change in disease status, and functional outcomes. RCTs were heterogenous regarding intervention protocols, patient populations, and outcomes reported. Multiple RCTs of US military service members showed no statistical difference in outcomes between HBOT groups and those that received sham treatment. Systematic reviews conducted pooled analyses only on a minority of the published RCTs, and these findings were inconsistent. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with inflammatory bowel disease who receive systemic HBOT, the evidence includes an RCT, observational studies, and a systematic review. Relevant outcomes are symptoms, change in disease status and functional outcomes. One small RCT has been published, and this trial did not find a significant improvement in health outcomes when HBOT was added to standard medical therapy. A systematic review including the RCT and observational studies found a high rate of bias in the literature due to attrition and reporting bias. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

A Cochrane review of RCTs had mixed findings from studies that included individuals with tinnitus. Some outcomes (ie, improvement in hearing of all frequencies, >25% return of hearing) were better with HBOT than with a control intervention, but more than 50% return of hearing did not differ significantly between groups. There was important variability in the patients enrolled in the studies. A subsequent systematic review had similarly limited conclusions due to the inclusion of non-randomized studies. One RCT included in this review included patients with idiopathic sudden sensorineural hearing loss and found no differences in HBOT treatment compared with steroid injections in mean hearing thresholds at 0.25, 0.5, 1, and 4 kHz; however, a significant difference was detected at the 2-kHz level. Nonrandomized studies of HBOT used as adjunctive therapy did not support incremental value, although 1 systematic review evaluated HBOT along with steroid therapy and found benefit specifically for those with severe-to-profound idiopathic sudden sensorineural hearing loss. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with delayed-onset muscle soreness who receive systemic HBOT, the evidence includes RCTs and a systematic review. Relevant outcomes are symptoms and functional outcomes. A Cochrane review of RCTs found worse short-term pain outcomes with HBOT than with control and no difference in longer-term pain or other outcomes (eg, swelling). The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with autism spectrum disorder who receive systemic HBOT, the evidence includes an RCT and a systematic review. Relevant outcomes are symptoms and functional outcomes. A Cochrane review identified a single RCT on HBOT for autism spectrum disorder and this trial did not find significantly better parental-assessed or clinician-assessed outcomes with HBOT compared with sham. A subsequent controlled trial reached the same conclusion. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with cerebral palsy who receive systemic HBOT, the evidence includes 2 RCTs and an observational study. Relevant outcomes are symptoms and functional outcomes. One RCT was stopped early due to futility, and the other did not find significantly better outcomes with HBOT than with a sham intervention. The observational study focused on sleep disorders in children with cerebral palsy and reported improvements with the HBOT treatment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with vascular dementia who receive systemic HBOT, the evidence includes an RCT and a systematic review. Relevant outcomes are symptoms and functional outcomes. The Cochrane review identified only a single RCT with methodologic limitations. Well-conducted controlled trials are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with radiotherapy adverse events who receive systemic HBOT, the evidence includes RCTs, nonrandomized comparator trials, case series, and systematic reviews. Relevant outcomes are symptoms and functional outcomes. Three systematic reviews included few RCTs and provide limited evidence on the effect of HBOT. Two RCTs identified had inconsistent findings. One reported no short-term benefit with HBOT, but some benefits 12 months after radiotherapy; the other did not find a significant benefit of HBOT at 12-month follow-up. Another RCT assessed HBOT for radiation-induced cystitis and found significant benefit by some measures but not others. An observational study for dry mouth (xerostomia) caused by radiotherapy found some benefit with HBOT. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with idiopathic femoral neck necrosis who receive systemic HBOT, the evidence includes an RCT. Relevant outcomes are symptoms, change in disease status, and functional outcomes. The RCT, which had a small sample, only reported short-term (ie, 6-week) outcomes. Larger well-conducted RCTs reporting longer-term outcomes are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a migraine who receive systemic HBOT, the evidence includes RCTs and a systematic review. Relevant outcomes are symptoms, change in disease status, and functional outcomes. The Cochrane review conducted a pooled analysis including 3 of the 11 trials. Meta-analysis of

these 3 RCTs found significantly greater relief of migraine symptoms with HBOT than with a comparator intervention within 45 minutes of treatment. Longer-term data are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with herpes zoster who receive systemic HBOT, the evidence includes an RCT. Relevant outcomes are symptoms and change in disease status. The RCT was unblinded and only reported short-term (ie, 6-week) outcomes. Additional well-conducted RCTs with longer follow-up are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with fibromyalgia who receive systemic HBOT, the evidence includes RCTs. Relevant outcomes are symptoms, change in disease status, and functional outcomes. Only 2 RCTs were identified, and both reported positive effects of HBOT on tender points and pain. However, the trials had relatively small samples and methodologic limitations (eg, quasi-randomization, no or uncertain sham control for a condition with subjective outcomes susceptible to a placebo effect). Moreover, the HBOT protocols varied. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with multiple sclerosis who receive systemic HBOT, the evidence includes RCTs and a systematic review. Relevant outcomes are symptoms and functional outcomes. A Cochrane review of RCTs did not find a significant difference in Expanded Disability Status Scale scores when patients with multiple sclerosis were treated with HBOT versus a comparator intervention. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with cancer and are undergoing chemotherapy who receive systemic HBOT, the evidence includes an RCT and a systematic review. Relevant outcomes are OS and change in disease status. While the systematic review reported improvements in tumor control in patients with head and neck cancer who received HBOT, the adverse events accompanying the treatment (eg, radiation tissue injury, seizures) were significant. The single RCT did not find a significant difference in survival for cancer patients who received HBOT before chemotherapy compared with usual care. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements

Infectious Disease Society of America

In 2012, the Infectious Disease Society of America published guidelines on the diagnosis and treatment of diabetic foot infections.⁷⁴ The guidelines stated that "for selected diabetic foot wounds that are slow to heal, clinicians might consider using hyperbaric oxygen therapy (strength of evidence: strong; quality of evidence: moderate)."

Society of Vascular Surgery et al

In 2016, the Society of Vascular Surgery in collaboration with the American Podiatric Medical Association and the Society for Vascular Medicine published guidelines on the management of the diabetic foot.⁷⁵ According to the guidelines, for diabetic foot ulcers that fail to demonstrate improvement (>50% wound area reduction) after a minimum of 4 weeks of standard wound therapy, adjunctive therapy such as HBOT is recommended (grade 1B). Also, for diabetic foot ulcers with adequate perfusion that fail to respond to 4 to 6 weeks of conservative management, HBOT is suggested (grade 2B).

Undersea and Hyperbaric Medical Society

In 2015, the Undersea and Hyperbaric Medical Society (UHMS) published guidelines on the use of hyperbaric oxygen therapy (HBOT) for treating diabetic foot ulcers.⁷⁶ Recommendations in the current version include:

- Suggest against using HBOT in patients with "Wagner Grade 2 or lower diabetic foot ulcers..."
- Suggest adding HBOT in patients with "Wagner Grade 3 or higher diabetic foot ulcers that have not shown significant improvement after 30 days of [standard of care] therapy..."
- Suggest "adding acute post-operative hyperbaric oxygen therapy to the standard of care" in patients with "Wagner Grade 3 or higher diabetic foot ulcers" who have just had foot surgery related to their diabetic ulcers.

The 2019 UHMS hyperbaric oxygen therapy indications committee report included the following indications as recommended:⁷⁷

1. Air or Gas Embolism
2. Carbon Monoxide Poisoning and carbon monoxide complicated by cyanide poisoning
3. Clostridial Myositis and Myonecrosis (Gas Gangrene)
4. Crush Injury, Compartment Syndrome and Other Acute Traumatic Ischemias
5. Decompression Sickness
6. Central retinal artery occlusion
7. Diabetic foot ulcer
8. Healing of other problem wounds
9. Severe anemia
10. Intracranial abscess
11. Necrotizing soft tissue infections
12. Refractory osteomyelitis
13. Delayed radiation injury (soft tissue and bony necrosis)
14. Compromised grafts and flaps
15. Acute thermal burn injury
16. Sudden Sensorineural hearing loss.

The UHMS has also published position statements that concluded there was insufficient evidence to recommend topical HBOT for chronic wounds (2005),⁷⁸ multiple sclerosis,⁷⁹ and autism spectrum disorder (2009).⁸⁰

American Academy of Otolaryngology-Head and Neck Surgery

In 2018, the American Academy of Otolaryngology-Head and Neck Surgery updated clinical guidelines on treatment of sudden hearing loss.⁸¹ They give the following options regarding HBOT:

"Clinicians may offer, or refer to a physician who can offer, hyperbaric oxygen therapy (HBOT) combined with steroid therapy within 2 weeks of onset of SSNH."

"Clinicians may offer, or refer to a physician who can offer, hyperbaric oxygen therapy (HBOT) combined with steroid therapy as salvage within 1 months of onset of SSNHL."

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

In 2003, the Centers for Medicare & Medicaid added Medicare coverage of HBOT for diabetic wounds of the lower extremities meeting certain criteria. As of the current coverage statement, Medicare coverage is provided for HBOT administered in a chamber for the following conditions⁸²:

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 3 criteria:
 1. Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;
 2. Patient has a wound classified as Wagner grade III or higher; and
 3. Patient has failed an adequate course of standard wound therapy."

The use of HBO therapy is covered as adjunctive therapy only after there are no measurable 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 any 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 are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment."

Systemic HBOT for other indications is not covered, nor is topical HBOT for any indication.

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POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

Date	Action	Description
September 2012	New Policy	
March 2014	Replace Policy	Policy updated with literature review. Bisphosphonate-related osteonecrosis of the jaw, motor dysfunction associated with stroke, herpes zoster and vascular dementia added as not medically necessary. References added; other references renumbered or removed. Additional conditions added as medically necessary.
December 2014	Replace Policy	Policy updated with literature review through July 17, 2014. In not medically necessary statement, severe or refractory Crohn's disease changed to inflammatory bowel disease (Crohn disease or ulcerative colitis). Clarification added to bullet point in not medically necessary statement on radiation-induced injury in the head and neck. Title changed from "Hyperbaric Oxygen Pressurization (HBO)" to "Hyperbaric Oxygen Therapy". References 2, 10, 12-13, 43-46, and 49 added.
December 2015	Replace Policy	Policy updated with literature review through June 17, 2015; references 27, 34, 40, 41 and 66-70 added. Bullet points on (1) fibromyalgia and (2) mental illness (i.e., posttraumatic stress disorder, generalized anxiety disorder or depression) added to the not medically necessary statement
March 2017	Replace Policy	Policy updated with literature review through November 8, 2016; references 6-7, 15, 22, 26-27, 39, 48, and 56 added. Policy statements unchanged.
March 2018	Replace Policy	Policy updated with literature review through November 6, 2017; references 1, 3, 12-13, 47, 58-59, 62-63, 65-67, and 69-70 added. Policy statements unchanged.
March 2019	Replace Policy	Policy updated with literature review through November 6, 2017; references 1, 3, 12-13, 47, 58-59, 62-63, 65-67, and 69-70 added. Policy statements unchanged.
March 2020	Replace Policy	Policy updated with literature review through November 11, 2019; references added. Policy statements unchanged except "not medically necessary" changed to "investigational" due to HBOT FDA 501(k) clearance.
March 2022	Replace policy	Policy updated with literature review through November 14, 2020; references added. Policy statements unchanged.