Medical Policy
Inhaled Nitric Oxide

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Policy Number: 100
BCBSA Reference Number: 8.01.37
NCD/LCD: N/A

Related Policies
None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO BlueSM and Medicare PPO BlueSM Members

Inhaled nitric oxide may be MEDICALLY NECESSARY as a component of treatment of hypoxic respiratory failure in neonates born at 34 or more weeks of gestation.

Other indications for inhaled nitric oxide are INVESTIGATIONAL including, but not limited to:
- Treatment of premature neonates born at less than or equal to 34 weeks of gestation with hypoxic respiratory failure
- Treatment of adults and children with acute hypoxemic respiratory failure
- Postoperative use in adults and children with congenital heart disease
- In lung transplantation, during and/or after graft reperfusion.

Prior Authorization Information

Inpatient
For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
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<th>Outpatient</th>
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<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is not required.</td>
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<tr>
<td>Commercial PPO and Indemnity</td>
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<tr>
<td>Medicare HMO BlueSM</td>
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CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

Description

Hypoxic Respiratory Failure

Hypoxic respiratory failure may result from respiratory distress syndrome, persistent pulmonary hypertension, meconium aspiration, pneumonia, or sepsis.

Treatment

Treatment typically includes oxygen support, mechanical ventilation, induction of alkalosis, neuromuscular blockade, or sedation.

Extracorporeal membrane oxygenation is an invasive technique that may be considered in neonates when other therapies fail. Inhaled nitric oxide (INO) is both a vasodilator and a mediator in many physiologic and pathologic processes. INO has also been proposed for use in preterm infants less than 34 weeks of gestation and in adults.

Also, there are several potential uses in surgery. One is the proposed use of INO to manage pulmonary hypertension after cardiac surgery in infants and children with congenital heart disease. In congenital heart disease patients, increased pulmonary blood flow can cause pulmonary hypertension. Cardiac surgery can restore the pulmonary vasculature to normal, but there is the potential for complications, including postoperative pulmonary hypertension, which can prevent weaning from ventilation and is associated with substantial morbidity and mortality. Another potential surgical application is the use of INO in lung transplantation to prevent or reduce reperfusion injury.

Summary

Inhaled nitric oxide (INO) is a natural vasodilator and has been studied for a variety of types of respiratory failure. Most commonly, it is used as an initial treatment for neonates with hypoxic respiratory failure to improve oxygenation and reduce the need for invasive extracorporeal membrane oxygenation. It is also proposed as a treatment for premature infants, critically ill children and adults with respiratory failure, as well as in the postoperative management of children undergoing repair of congenital heart disease and patients after lung transplantation to prevent or reduce reperfusion injury.

For individuals who are neonates, are term or late preterm at birth, and have hypoxic respiratory failure who receive INO, the evidence includes randomized controlled trials (RCTs) and a systematic review. The relevant outcomes are overall survival (OS), hospitalizations, resource utilization, and treatment-related morbidity. Evidence from RCTs and a meta-analysis have supported the use of INO in term or late preterm infants. Pooled analyses of RCT data have found that use of INO significantly reduced the need for extracorporeal membrane oxygenation and the combined outcome of extracorporeal membrane oxygenation or death. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who are neonates, are premature at birth, and have hypoxic respiratory failure who receive INO, the evidence includes RCTs and systematic reviews. The relevant outcomes are OS, hospitalizations, resource utilization, and treatment-related morbidity. A large number of RCTs have evaluated INO for premature neonates, and most trials have reported no significant difference for
primary endpoints such as mortality and bronchopulmonary dysplasia. Meta-analyses of these RCTs have not found better survival rates in patients who received INO compared with a control intervention. Most meta-analyses also did not report improvements in other outcomes with INO (eg, bronchopulmonary dysplasia, intracranial hemorrhage). The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults and children in acute hypoxemic respiratory failure who receive INO, the evidence includes RCTs and systematic reviews. The relevant outcomes are OS, hospitalizations, resource utilization, and treatment-related morbidity. A large number of RCTs have evaluated INO for treatment of acute hypoxemic respiratory failure. Meta-analyses of these RCTs have not found that INO significantly reduced mortality or shortened the duration of mechanical ventilation. Some evidence from a meta-analysis of four RCTs and a cohort study has suggested that INO may be associated with an increased risk of renal impairment in patients with acute respiratory distress syndrome. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults and children with congenital heart disease who have had heart surgery who receive INO, the evidence includes RCTs and a systematic review. The relevant outcomes are OS, hospitalizations, resource utilization, and treatment-related morbidity. Evidence from a number of small RCTs and a systematic review of these trials did not find a significant benefit for INO on mortality and other health outcomes in the postoperative management of children with congenital heart disease. There is less evidence on INO for adults with congenital heart disease. One RCT found that treatment with INO did not improve the postoperative outcomes of adults with congestive heart failure. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have lung transplant who receive INO, the evidence includes RCTs and a systematic review. The relevant outcomes are OS, hospitalizations, resource utilization, and treatment-related morbidity. Several small RCTs have evaluated INO after lung transplantation; none found statistically significant improvements in health outcomes with INO. A systematic review of RCTs and observational studies concluded that available evidence did not support the routine use of INO after lung transplant. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Policy History**

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<th>Date</th>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References