

## Hyperbaric Oxygen (HBO) Pressurization

**Hyperbaric Oxygen (HBO) Pressurization  
Medical Policy – THE801.003**

Please complete all appropriate questions fully.

Suggested medical record documentation:

- Current History & Physical
- Consultation Reports
- Operative or Treatment Reports (other applicable hospital records)
- Provider Office Reports
- Photographs

\*Failure to include suggested medical record documentation may result in delay or possible denial of request.

**Note:** Per Medical Policy, HBO therapy using topical HBO pressurization for any indication or clinical condition is considered experimental, investigational and unproven.

**For Predetermination,** please fully complete and submit the [Predetermination Request Form](#).

**PATIENT INFORMATION**

Name:	Member ID	Group ID
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**PROCEDURE INFORMATION**

**Request for Systemic HBO: Please complete all the questions fully.  
Failure to do so will result in delay or possible denial of claims.**

Primary Diagnosis \_\_\_\_\_ Date \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_ Date \_\_\_\_\_

Contributing Factor(s) resulting in diagnosis \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Conservative Therapy done?    Yes \_\_\_\_\_    No \_\_\_\_\_

    If Yes, type and duration of Conservative Therapy \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ # of Months \_\_\_\_\_

For Wounds, Photographic Evidence included with HBO request?    Yes \_\_\_\_\_    No \_\_\_\_\_

Is this an initial request for HBO?    Yes \_\_\_\_\_    No \_\_\_\_\_

    If Yes, number of treatments (or dives) requested \_\_\_\_\_

    If No, number of previous treatments (or dives) completed \_\_\_\_\_

    If No, number of additional treatments (or dives) requested \_\_\_\_\_

**Part A – IF Condition is a Wound**

Cause of wound \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Location of wound \_\_\_\_\_

Description of wound \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Wound measurements \_\_\_\_\_  
 \_\_\_\_\_

Pathology or Culture report of wound \_\_\_\_\_

Wagner Classification of Wound (Grade #) \_\_\_\_\_

**Proceed to Part B if Request is for additional HBO Treatments (or Dives) ONLY**

**Part B – Additional HBO Treatment Requests**

Explanation of Reason for additional Systemic HBO Therapy: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is additional Conservative therapy being planned?      Yes \_\_\_\_\_      No \_\_\_\_\_

    If Yes, type and duration of Conservative Therapy \_\_\_\_\_  
 \_\_\_\_\_ # of Months \_\_\_\_\_

**In addition, IF the request is due to a wound, complete the following:**

Current Description of wound \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Wound measurements \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Previous Weekly Wound measurements for comparison and progression of healing since last request:

<b>Date</b>	<b>Wound Size (cm)</b>	<b>Wound depth (cm)</b>	<b>Undermining (cm)</b>	<b>Granulation</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Wagner Classification of Wound (Grade #) \_\_\_\_\_

For Wounds, updated Photographic Evidence included with HBO request?    Yes \_\_\_\_\_    No \_\_\_\_\_