[Physician Name]
[NPI Number]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Medical Review/Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Hyperbaric Oxygen Therapy (HBOT)
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Case/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally request authorization for Hyperbaric Oxygen Therapy (HBOT) for [Patient Name], who has been diagnosed with Chronic Refractory Osteomyelitis (ICD-10 Code: [Code]).

Clinical Documentation:
The patient has been suffering from persistent bone infection of the [Location of Bone] since [Date]. Despite aggressive medical and surgical interventions, the infection remains unresolved. Current clinical status includes [List symptoms: e.g., draining sinus tract, localized pain, swelling, or non-healing wound].

Treatment History:
This condition is classified as "refractory" as it has failed to respond to the following standard treatments:

- **Surgical Interventions:** [Dates and types of debridement or hardware removal].
- **Antibiotic Therapy:** [List specific antibiotics, durations, and delivery methods, e.g., 6 weeks of IV Vancomycin].
- **Imaging/Diagnostic Confirmation:** [Reference MRI, Bone Scan, or Biopsy results confirming persistent infection].

Rationale for HBOT:
Chronic refractory osteomyelitis often exists in a hypoxic environment where standard antibiotic delivery and leukocyte function are compromised. HBOT is medically necessary to increase tissue oxygen tension, enhance the oxidative killing mechanisms of neutrophils, and stimulate

osteoclast activity for necrotic bone resorption. HBOT also works synergistically with [Current Antibiotic] to improve penetration into the infected bone tissue.

Proposed Treatment Plan:
I am prescribing [Number, e.g., 30 to 40] HBOT sessions at [Pressure, e.g., 2.0 to 2.5 ATA] for [Duration, e.g., 90 minutes] per day, 5 days per week. The patient's progress will be re-evaluated after [Number] sessions to determine the need for further treatment.

Based on the refractory nature of this patient's condition and the risk of further complications, including [Amputation/Sepsis], HBOT is a vital component of the treatment plan. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Specialty]