

Date: [Date]

To: [Insurance Company Name]

Attn: Medical Review/Prior Authorization Department

Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Hyperbaric Oxygen Therapy (HBOT)

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy ID: [Member ID Number]

Group Number: [Group Number]

ICD-10 Code: [Insert Code, e.g., T86.828 (Skin graft failure) or T86.829]

Dear Medical Reviewer,

I am writing to formally request authorization for Hyperbaric Oxygen Therapy (HBOT) for the above-referenced patient. This treatment is medically necessary for the management of a **compromised skin graft/flap**.

Clinical History:

The patient underwent a [Type of Procedure, e.g., pedicle flap/split-thickness skin graft] on [Date of Surgery] at the anatomical site of [Body Location]. The procedure was necessitated by [Original Diagnosis/Reason for Surgery].

Current Status:

Upon recent evaluation on [Date], the graft/flap shows signs of compromise, including: [List signs: e.g., cyanosis, pallor, delayed capillary refill, marginal necrosis, or partial dehiscence].

Medical Necessity:

Conventional treatments, including [List treatments: e.g., wound care, antibiotics, surgical debridement], have been utilized but are insufficient to ensure graft/flap viability. HBOT is indicated here to increase dissolved plasma oxygen levels, stimulate angiogenesis, and reduce edema in the ischemic tissue. Per CMS and Undersea and Hyperbaric Medical Society (UHMS) guidelines, HBOT is a standard of care for the preservation of compromised skin grafts and flaps to prevent total tissue loss and subsequent surgical failure.

Proposed Treatment Plan:

I am prescribing [Number] sessions of HBOT at [Pressure, e.g., 2.0 or 2.4] ATA for [Duration, e.g., 90 minutes] per day. The patient will be re-evaluated weekly to monitor progress.

Failure to provide this treatment puts the patient at high risk for complete graft/flap loss, necessitating further invasive surgeries and prolonged hospitalization.

Thank you for your prompt attention to this urgent request. If you require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Facility Name]