

Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review Department
Address: [Insurance Company Address]

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

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

I am writing to formally request authorization for Hyperbaric Oxygen Therapy (HBOT) for the above-mentioned patient, who is currently under my care for the treatment of an intracranial abscess (ICD-10 Code: [Insert Code, e.g., G06.0]).

Clinical History:

The patient was diagnosed with an intracranial abscess on [Date] via [CT/MRI imaging]. The clinical course has included [List prior treatments, e.g., surgical aspiration/drainage, specific IV antibiotic regimens]. Despite these interventions, the patient continues to experience [List symptoms or lack of progress, e.g., persistent neurological deficits, failure of lesion to regress].

Medical Necessity:

Hyperbaric Oxygen Therapy is a recognized and standard adjunctive treatment for intracranial abscesses, particularly when they are multiple, located in deep or dominant brain structures, or when the patient is immunocompromised. HBOT is medically necessary for this patient to:

- Increase oxygen tension in the infected tissue to inhibit anaerobic bacteria.
- Enhance the white blood cell killing capacity (phagocytosis).
- Reduce perifocal cerebral edema.
- Improve the penetration and effectiveness of specific antibiotics across the blood-brain barrier.

Treatment Plan:

I am prescribing a course of HBOT at [Pressure, e.g., 2.0 or 2.5 ATA] for [Duration, e.g., 90 minutes] per session. We anticipate a total of [Number] sessions, to be re-evaluated based on follow-up imaging and clinical response.

In view of the life-threatening nature of this condition and the potential for permanent neurological damage, I request an expedited approval for this life-saving treatment.

Please contact my office at [Phone Number] if you require further documentation or clinical notes.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Board Certification/Specialty]

[NPI Number]

[Facility Name]