Hyperbaric Oxygen Therapy (HBOT) Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered, underwritten and/or administered by the following:

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner | Aetna)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna)

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About this form

You can't use this form to initiate a precertification request. To initiate a request, call our Precertification Department or you can submit your request electronically. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.**

This form replaces all other Hyperbaric Oxygen Therapy (HBOT) precertification information request documents and forms. This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

How to fill out this form

As the patient's attending physician, you must complete all sections of the form. You can use this form with all Aetna health plans, including Aetna's Medicare Advantage plans.

When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- We prefer you submit precertification requests electronically. Use our provider portal on Availity® to also upload clinical documentation, check statuses, and make changes to existing requests. **Register today at availity.com/aetnaproviders.**

- Email requests that require photographs to:
  - Commercial Plans: **VFAXPrecert@aetna.com**
  - Medicare Advantage Plans: MedicarePrecert@aetna.com

- Send your information via confidential fax to: Precertification – Commercial and Medicare (**including expedited**) using FaxHub: **1-833-596-0339**
  - The fax number above (FaxHub) is for clinical information only. Please send specific information that supports your medical necessity review. Please continue to send all other information (claims etc.) to appropriate fax numbers.

- Mail your information to: **PO Box 14079**
  Lexington, KY 40512-4079

What happens next?

Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic precertification response.

How we make coverage determinations

If you request precertification for a Medicare Advantage member, we use CMS benefit policies, including national coverage determinations (NCD) and local coverage determinations (LCD) when available, to make our coverage determinations. If there isn't an available NCD or LCD to review, then we'll use the Clinical Policy Bulletin referenced below to make the determination.

For all other members, we encourage you to review **Clinical Policy Bulletin #172: Hyperbaric Oxygen Therapy (HBOT),** before you complete this form.

You can find the Clinical Policy Bulletins and Precertification Lists by visiting the website on the back of the member's ID card.

Questions?

If you have any questions about how to fill out the form or our precertification process, call us at:

- HMO Plans: **1-800-624-0756**
- Traditional Plans: **1-888-632-3862**

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Section 1: Provide the following general information If submitting request electronically, complete member name, ID and reference number only	
Member name:	**Reference number (required)**
Member ID:	**Member date of birth:**
Facility, Physician, Provider or Vendor name and NPI:	
Facility, Physician, Provider or Vendor phone number: 1- - -	
Facility, Physician, Provider or Vendor fax number: 1- - -	
Referring physician name:	
Referring physician phone number: 1- - -	**Referring physician fax number:** 1- - -

Section 2: Select the HBOT indication(s) that applies to your patient

- ☐ Acute air or gas embolism ☐ Acute carbon monoxide poisoning ☐ Acute cerebral edema
- ☐ Acute traumatic peripheral ischemia (including crush injuries and suturing of severed limbs) when loss of function, limb, or life is threatened and HBOT is used in combination with standard therapy
- ☐ Chemotherapy-induced hemorrhagic cystitis ☐ Cyanide poisoning (with co-existing carbon monoxide poisoning)
- ☐ Decompression illness ("the bends")
- ☐ Exceptional blood loss anemia only when there is overwhelming blood loss and transfusion is impossible because there is no suitable blood available, or religion does not permit transfusions
- ☐ Gas gangrene (Clostridial myositis and myonecrosis)
- ☐ Idiopathic sudden deafness, acoustic trauma or noise-induced hearing loss, when HBOT is initiated within 3 months after onset
- ☐ Pneumatosis cystoides intestinalis
- ☐ Prophylactic pre- and post-treatment for members undergoing dental surgery of a radiated jaw, where the extraction site is anticipated to be within the XRT portal, and where HBOT is delivered according to established (Marx) protocol, with 20 HBOT treatments prior to surgery and 10 HBOT treatments immediately after surgery
- ☐ Radiation-induced hemorrhagic cystitis
- ☐ Radiation necrosis (brain radionecrosis, myoradionecrosis, osteoradionecrosis, and other soft tissue radiation necrosis)
- ☐ Radiation proctitis

☐ Acute peripheral arterial insufficiency (i.e., compartment syndrome) requiring emergent surgical intervention (e.g., surgical or catheter directed embolectomy or bypass surgery), with imaging documentation of embolus/thrombus (e.g., MR, angiogram)

Date of surgery: / /

Submit the following:

☐ **Imaging report(s) with documentation of embolus/thrombus** ☐ **Operative report**

☐ Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management, including a six- week course of parenteral antibiotics and at least one surgical eradication/debridement attempt, unless contraindicated, with dated photograph (with ruler) of wound plus X-ray or bone culture documenting diagnosis

Name of antibiotic:

Date range for antibiotics: / / **to** / /

Date(s) of surgical eradication/debridement: / / / / / /

Submit the following documentation:

☐ **Operative report(s)** ☐ **Dated photograph (with ruler) of wound**

☐ **X-ray or bone culture report(s) documenting diagnosis**

Member ID:	**Reference Number:**

Section 2 Continued: Select the HBOT indication(s) that applies to your patient

☐ Compromised skin grafts and flaps, where hypoxia or decreased perfusion has compromised viability acutely, preparation and preservation (not for primary management of wounds or maintenance of split thickness skin grafts or artificial skin substitutes) excluding artificial skin grafts.

Type of flap **Name of surgeon performing graft or flap**

Was there surgical exploration? ☐ **Yes** ☐ **No**

Were there any split thickness skin grafts (STSG) or bioengineered skin substitutes used? ☐ **Yes** ☐ **No**

Submit the following documentation:

☐ **Operative report** ☐ **Dated photograph (with ruler) of wound**

☐ **Transcutaneous oxygen tension testing demonstrating hypoxia of flap or graft (TcPO2 less than 40 mm Hg on room air)**

☐ Non-healing infected deep ulcerations (reaching tendons or bone) of the lower extremity in diabetic adults unresponsive to at least 1 month of meticulous wound care. **Wagner grade**

Submit the following documentation:

☐ **Dated photograph (with ruler) of wound**

☐ **Size of wound:** **cm long x** **cm wide x** **cm deep**

Wound description:

☐ **Wound care documentation must include the following:**

- Assessment of vascular status and correction of any vascular problems in the affected limb if possible
- Optimization of nutritional status **Pre-albumin** **Date:** / /
- Optimization of glucose control **HgA1C** **Date:** / /
- Debridement by any means to remove devitalized tissue
- Maintenance of clean, moist bed of granulation tissue with appropriated moist dressings
- Appropriate off-loading
- Necessary treatment to resolve any infection that might be present.
- Length of wound care treatment(s)

Note: Wounds must be evaluated, with photographic documentation with ruler, after every 15 treatments and/or at least every 30 days during administration of HBOT. Continued treatment with HBOT is not considered medically necessary if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

☐ Progressive necrotizing soft tissue infections, including mixed aerobic and anaerobic infections (Meleney's ulcer, necrotizing fasciitis), with history of inpatient treatment including antibiotics and surgical debridement, unless contraindicated, and (where appropriate) full thickness or split thickness skin grafts, and with photographic documentation (with ruler) of the wound

Name of antibiotic:

Date range for antibiotics: / / **to** / /

Date(s) of inpatient treatment(s): ☐ N/A / / / / / /

Date(s) of surgical debridement(s): ☐ N/A / / / / / /

Date(s) of skin graft(s): ☐ N/A / / / / / /

Submit the following documentation:

☐ **Dated photograph (with ruler) of wound** ☐ **Operative report(s)**

☐ Other – Please Specify

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Member ID:	Reference Number:

Section 3: Provide the following information for your HBOT request

☐ **New service (valid for 30 days)** ☐ **One continuation of care (valid for 30 days)**
Note: HBOT for more than 2 months is usually not necessary.

Estimated length of each treatment (in minutes):

Date of Service	Provider	Provider NPI Number

Section 4: Provide the following documentation for your request

- Current history and physical
- Office notes related to the member's condition for which treatment is proposed
- Dated photograph (with ruler) of wound
- Description of proposed treatment
- Lab/pathology and x-ray reports, if applicable
- Operative report(s), if applicable
- Any supporting medical records documenting clinical finding, conservative management with outcome, and current plan of care

Section 5: Read this important information

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Section 6: Sign the form

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:
Telephone number: 1- - -