

**Hyperbaric oxygen therapy — outpatient (BCN Advantage members)**

Services must meet medical necessity criteria. Submit prior authorization requests through the e-referral system. The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and the plan cannot authorize it, the plan will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. Compliance with this prior authorization requirement will be monitored retrospectively.

**Applicable codes:** \*99183 and G0277

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**See below for the questions you'll encounter for this procedure in the e-referral system.**

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

**Hyperbaric Oxygen Therapy\_BCNA**

**Q** Is this an INITIAL request for hyperbaric oxygen therapy for a condition OTHER THAN a wound?

**A**  Possible answers:  Yes  No  NA

**Q** Is this an EXTENSION request for ONGOING hyperbaric oxygen therapy for a condition OTHER THAN a wound?

**A**  Possible answers:  Yes  No  NA

**Q** Is this an INITIAL request for HBO therapy for a patient with a NON-DIABETIC wound that is NOT a skin, pressure or stasis ulcer WITH NO measurable signs of healing FOR AT LEAST 30 days OR failure to respond to standard wound care WITH ALL of the following (A-G)? a) Vascular status assessment and correction if possible. b) Optimization of nutrition. c) Optimization of blood glucose control. d) Debridement of devitalized tissue. e) Maintenance of a clear, moist bed of granulation tissue with appropriate moist dressings. f) Off-loading to reduce pressure on the wound. g) Treatment to resolve any infection that might be present.

**A**  Possible answers:  Yes  No  NA

**See below for the questions you'll encounter for this procedure in the e-referral system. (continued)**

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

<p><b>Q</b></p> <p><b>A</b> <input type="text"/></p>	<p>Is this an INITIAL request for HBO therapy for a DIABETIC patient WITH a wound of the lower extremity THAT IS classified as Wagner grade III or higher AND failure to respond to standard wound care WITH ALL of the following (A-G)? a) Vascular status assessment and correction if possible. b) Optimization of nutrition. c) Optimization of blood glucose control. d) Debridement of devitalized tissue. e) Maintenance of a clear, moist bed of granulation tissue with appropriate moist dressings. f) Off-loading to reduce pressure on the wound. g) Treatment to resolve any infection that might be present.</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b></p> <p><b>A</b> <input type="text"/></p>	<p>Is this an EXTENSION request for ONGOING HBO therapy for a patient with a WOUND (either diabetic or non-diabetic) that has been evaluated AT LEAST every 30 days during HBO therapy AND the patient's record documents measurable signs of healing (for example, width, depth and length of the wound)? You MUST submit clinical information via the Provider Communication field of e-referral on the location, size of the wound and progression of healing while undergoing HBO therapy.</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b></p> <p><b>A</b> <input type="text"/></p>	<p>Does the patient have a sudden and severe onset of carbon monoxide poisoning?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b></p> <p><b>A</b> <input type="text"/></p>	<p>Does the patient have a sudden and severe onset of peripheral arterial insufficiency?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b></p> <p><b>A</b> <input type="text"/></p>	<p>Does the patient have a sudden and severe onset of traumatic peripheral ischemia (inadequate supply of blood to organs and body tissues as a result of a severe physical injury) AND the threat of loss of function, limb, or life?</p> <p>Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>

**See below for the questions you'll encounter for this procedure in the e-referral system. (continued)**

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

<p><b>Q</b> Does the patient have a sudden and severe onset of cyanide poisoning?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have a sudden and severe onset of gas embolism (blood vessel blockage caused by one or more bubbles of air)?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have chronic osteomyelitis (bone infection) AND is not responding to standard medical and surgical management?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have a crushing injury where force or pressure is put on a body part OR suturing of severed limbs AND the threat of loss of function, limb or life is threatened?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have decompression illness caused by a rapid decrease in pressure in either the air or water (such as high-altitude air travel, unpressurized air travel, or ascending from deep water)?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have gas gangrene (a bacterial infection that produces gas in tissues)?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>

**See below for the questions you'll encounter for this procedure in the e-referral system. (continued)**

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

<p><b>Q</b> Does the patient have EITHER osteoradionecrosis (bone destruction due to radiation); OR soft tissue radiation necrosis (destruction) NOT related to either the spinal cord, bladder, intestines or rectum; AND this therapy will be used in addition to standard treatment?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have a compromised skin graft AND this therapy will be used for preparation and preservation of the skin grafts AND NOT for primary management of a wounds?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have a progressive necrotizing infection (rapid tissue inflammation and death)?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p><b>Q</b> Does the patient have actinomycosis (a rare infection bacterial disease) AND this therapy is being requested as a supplement to conventional therapy AND the disease process is not responding to antibiotics and surgical treatment?</p> <p><b>A</b> <input type="text"/> Possible answers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>