Patient Name:

SerenaGroup Hyperbaric Oxygen Therapy Checklist

Hyperbaric Oxygen Therapy - Eval, Criteria and Pre-Treatment Checklist (Refer to either NCD 20.29 or regional LCD for correct ICD 10 codes)

Consult must be done, and each Pertinent Criteria below MUST be clearly described in Hyperbaric Evaluation

Actinomycosis		
	Need	Prolonged administration of antibiotics
	Need	Must document that disease is refractory to antibiotics and surgery.
	Need	Documentation of actinomyces israelii infection
Crush Injuries and Suturing of Severed Limb		
** RE-EVAL after 12 treatments*		
	Need	Documentation of loss of function, limb or life being threatened
	Supports	TCOM <30 mm/Hg
Diabetic Foot Ulcers (regardless of grade)		
**RE-EVAL Q 30 Days - Must show signs of measureable improvement to continue past 30 days*		
	Need	Documentation of Type I or Type II diabetes with lower extremity diabetic wound
	Need	Documentation of Wagner III or higher
	Need	Documentation of standard wound care for 30 days with no measureable signs of healing.
Standard wound care must include all the following:		
	Need	Vascular Assessment and correction of issue
	Need	Optimization of glucose & education
	Need	Optimization of nutritional status & education
	Need	Debridement by any means to remove devitalized tissue
	Need	Maintenance of a clean moist wound bed
	Need	Appropriate offloading
	Need	Treatment to resolve infection
	Support	ABI >.6
Diabetic Ulcer Wagner III (must meet SOC for 30 days)		
	Need	Documentation of one or more: Tendonitis, Osteomyelitis, Osteitis, Abscess, Pyarthrosis
Diabetic Ulcer Wagner IV		
	Need	Documentation of Wet or Dry gangrene of the toes or forefoot
Diabetic Ulcer Wagner V		
	Need	Documentation of gangrene involving entire foot
Soft Tissue Radionecrosis-Late Effects of Radiation		
	Need	Documented dates, dosage, anatomical site, and # of treatments of prior radiation. Must be ≥ 6 months post radiation
	Need	Documentation of treatment with conventional therapy

Acute Peripheral Arterial Insufficiency		
	Need	Documentation of sudden occlusion of a major artery- Which:
	Need	Vascular study to confirm i.e. CTA/MRA/Arteriogram
	Need	Revascularization Candidate? Yes / No
** If NO: reason in Hyperbaric evaluation note*		
	Supports	In Chamber, TCOM to show response to O2 w/ 1st TX
Acute Traumatic Peripheral Ischemia		
	Need	Documentation of loss of function, limb, or life threatened (i.e. injury that compromises circulation)
	Supports	TCOM <30 mm/Hg, LUNA, SPP/PVR
Gas Gangrene		
**Adjunct to antibiotic therapy & surgery*		
	Need	Clinical sign and symptoms
	Supports	X-ray findings
Progressive Necrotizing Infections		
	Need	Documentation of laboratory reports that confirms the diagnosis of progressive necrotizing infection
	Need	Culture or gram stain that confirms diagnosis of Meleney Ulcer
Skin Graft/Flap Failure		
	Need	Documentation of graft date
	Need	Documentation of compromised state of graft site
Complications of Reattachment Extremity or Body Part		
	Need	Documentation of flap date
	Need	Documentation of compromised state of flap site
Chronic Refractory Osteomyelitis		
	Need	Definitive evidence condition is chronic & unresponsive to conventional tx (ABX/wound care)
	Need	Definitive imaging (i.e. MRI, X-ray, Bone Scan) and bone culture with C&S
	Need	Failed appropriate antibiotic regimen
	Need	Bone debridement (when possible)
Osteoradionecrosis		
	Need	Documented dates, dosage, anatomical site, and # of treatments of prior radiation. Must be ≥ 6 months post radiation
	Need	Diagnosis from referring physician
	Need	Plan to or documented debridement/resection of non-viable tissue if present in conjunction w/ antibiotics

Absolute Contraindications (NOTE- cannot treat until corrected)		
YES	**NO**	
		Untreated Pneumothorax

Relative Risk/Contraindication-Discuss with patient (NOTE- does not preclude treatment)					
YES	**NO**		**YES**	**NO**	
		1. Upper Respiratory Infections			10. Viral Infections
		2. Chronic Sinusitis			11. Congenital Spherocytosis
		3. Seizure Disorders			12. Asymptomatic Pulmonary Lesions on X-Ray
		4. Cardiomyopathy / CHF			13. Pregnancy
		5. Uncontrolled High Fever			14. Body Temperature
		6. History of Spontaneous Pneumothorax			15. Blood Glucose Levels
		7. History of Thoracic Surgery			16. History of previous ear or sinus surgery
		8. History of Surgery for Otosclerosis			17. Pulse and blood pressure
		9. Claustrophobia			18. Severe Emphysema/COPD with CO^2 Retention

**Please note that some commercial insurance companies have extended indications and criteria for HBOT which may not be included in the above CMS guidelines. Case managers will discuss these on a case-by-case basis with the attending physician during work up for HBOT based on the coverage guidelines of the patient policy.*

Required Pre-Treatment Testing

Test	**Date Performed**	**Notes:**
Chest X-Ray		
EKG		

**Completed within 6 months for asymptomatic patients is acceptable. Obtain record/result. This must be reviewed and cleared by the hyperbaric physician before the first treatment.*

Hyperbaric Evaluation Physician Notes- if a decision to not treat is decided please provide reasoning & rationale below.

Provider Signature **Date/Time**

SerenaGroup Chief Quality Officer **SerenaGroup Medical Director**

This form was completed by

NOTE TO CLINICIANS: Once this form is completed, it needs to be scanned into the Hospital EMR, Intellicure, Wound Expert, etc.