



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

PANNICULECTOMY PRIOR AUTHORIZATION REQUEST

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ RECIPIENT MEDICAID ID #: _____

RECIPIENT HEIGHT: _____ RECIPIENT WEIGHT: _____

DIAGNOSIS: _____ ICD-9: _____ CPT: _____

PROVIDER INFORMATION

DATE OF REQUEST: ____/____/____ CONTACT PERSON: _____

PROVIDER NAME: _____ NH MEDICAID PROVIDER #: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

TELEPHONE #: _____ FAX #: _____

MEDICAL NECESSITY CRITERIA FOR PANNICULECTOMY

A Panniculectomy **may** be covered for non-cosmetic indications for Medicaid recipients 18 years of age or older, when **all of the following criteria are met**. Please check all that apply.

The pannus hangs at or below the level of the symphysis;

AND

Is unresponsive to treatment including adequate hygiene and topical anti-infective medications;

AND

Causes recurrent and significant bacterial or fungal skin infection that has failed at least 2 treatments with an oral antibiotic;

AND

Has been present for over a 6-month period resulting in fibrosis and thickening of the pannus with discoloration and/or lymphedema or peau d'orange effect (pitting or prominence of pore due to fibrosis and swelling) of the overlying skin;

AND (if applicable)

If there has been a significant weight loss (> 100 lbs.) the recipient must meet the criteria above;

AND

a. If the weight loss was accomplished without bariatric surgery, the recipient must have maintained a stable weight for a minimum of 6 months;

OR

b. If the weight loss is a result of bariatric surgery, a panniculectomy will not be considered for prior authorization until at least 18 months after surgery and only after weight has been stable for at least 6 months.

*****LIMITATION TO SERVICE: This service has a limit of once per lifetime*****

CLINICAL INFORMATION:

The following may be requested for verification of above information:

- Preoperative photograph(s) are required, frontal and lateral views.
- History and physical including all previous surgeries including the recipient's weight loss history.
- Medical documentation of medical conditions and complications of infections outlining all treatments including duration and responses.
- Documentation of limitations on mobility and daily activities due to the pannus or resulting complications.

CERTIFICATION OF MEDICAL NECESSITY

I certify that the above information is true and accurate to the best of my knowledge.

Signature

Date

Print

Name/Title

Specialty

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

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