



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: _____

DOES RECIPIENT HAVE ALTERNATE INSURANCE PLAN? YES NO

NAME OF INSURANCE PLAN: _____

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:

- 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 or 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

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.

8 Commerce Drive ■ 2nd Floor ■ Bedford, NH 03110 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335



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PANNICLECTOMY PRIOR AUTHORIZATION REQUEST

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

Please print:

Name/Title

Specialty

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