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JURISDICTION 15 PART A

PRIOR AUTHORIZATION OPD: PANNICULECTOMY

PAR 254

All fields are REQUIRED unless otherwise noted.
Incomplete or illegible handwritten requests will be returned.

Note: Use of this request document will require submission via fax, mail, or the electronic submission of Medical Documentation (esMD). To save time, use the myCGS web portal to submit your request, upload your documentation electronically, track the status of your request, and receive a quicker response.

Request Type ______

Expedited Reason ______

Note: *Provide reason for expediting request if Expedited Initial or Expedited Resubmission Request Type is selected above.*

Requested HCPCS (maximum of 4)

______

______

______

______

UTN ______

Note: *Only required for Resubmissions & Expedited Resubmissions. Enter the UTN of most recent submission.*

Primary Diagnosis Code ______

Date of Service ______

Type of Bill ______

FACILITY INFORMATION

Facility Name ______

PTAN ______

NPI ______

Region ______

Note: **Facility information should be the Hospital Outpatient Department information.**

Fax Number ______

Note: **If submitting by fax, fax number is required. The fax number must be the fax number of the Hospital Outpatient Department.** *If submitting by mail or esMD, fax number is optional. If you want to also receive the decision letter via fax, provide a fax number. A decision letter will be sent by mail to the provider address on file.*

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name ______

Medicare ID ______

ATTENDING PHYSICIAN INFORMATION

Physician Name ______

NPI ______

REQUESTOR INFORMATION

Requestor Name ______

Phone Number ______

Date ______

Email ______

FOR OFFICE USE ONLY

Fax to: 1.615.782.4486

Mail to: CGS
PO Box 20203
Nashville, TN 37202

For additional information, please visit our website at: https://www.cgsmedicare.com/parta/mr/opd.html

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Please answer and follow the instructions for each question below.

QUESTIONS

Q1. Is the Panniculectomy being performed as a secondary procedure to allow the primary surgical procedure to be performed for one of the following reasons? **Yes** **No** **Not Applicable**

- Adipose tissue is so thick even the longest surgical equipment cannot reach site of dissection
- Grade 3 Panniculus or higher that increases risk of poor wound healing
- Other documented reason surgery cannot be performed or substantially increased risk without Panniculectomy

Comments:

Q2. Is the procedure being performed primarily for any of the following reasons? **Yes** **or No**

- Treatment of neck or back pain
- Improving appearance (i.e., cosmesis)
- Repairing abdominal wall laxity or diastasis recti
- Treating psychological symptomatology or psychosocial complaints
- In conjunction with abdominal or gynecological procedures (e.g., Abdominal hernia repair, Hysterectomy, obesity surgery) unless criteria for Panniculectomy and Abdominoplasty are met separately
- Hernia repair

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

Q3. Is the panniculus a Grade 1-5? **Yes** **or No**

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

Q4. Were conservative treatment measures attempted OR is there a significant functional deficit? **Yes** **or No**

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

Q5. Is the procedure being performed following significant weight loss (14 BMI points or BMI≤30) as a result of bariatric surgery; has weight loss remained stable for 3-6 months; and is the beneficiary ≥ 18 months post surgery? **Yes** **or No**

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

Note: Attach supporting documentation for condition and associated symptoms, rationale for treatment procedure, etc. and/or comment..

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DOCUMENTATION

Condition and Associated Symptoms/ Rationale for Treatment Procedure

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