

PRIOR AUTHORIZATION ASC: PANNICULECTOMY

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 CPTs (maximum of 3)

Primary Diagnosis Code

Date of Service

UTN

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

ASC INFORMATION

ASC Name

PTAN

NPI

Region

Fax Number

Note: If submitting by fax, fax number is required.

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

PERFORMING SURGEON INFORMATION

Surgeon Name

NPI

Address

Fax Number

REQUESTOR INFORMATION

Requestor Name

Email

Date

Phone Number

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JURISDICTION 15 PART B OHIO

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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
- In conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, buried penis syndrome and obesity surgery) unless criteria for panniculectomy and abdominoplasty are met separately
- Hernia repair

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

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 as a result of bariatric surgery; has weight loss remained stable for 6 months; and is the beneficiary \geq 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..*

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

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DOCUMENTATION

**Condition and Associated Symptoms/
Rationale for Treatment Procedure**