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## **1.0 Description of the Procedure**

Panniculectomy is the removal of excessive skin, subcutaneous tissue, and fat of the abdomen.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

**Basic Medicaid Billing Guide:** <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### 3.0 When the Procedure Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

#### 3.1 General Requirements

Panniculectomy is covered when a recipient is 19 years of age or older, **and**

- a. Has a BMI of 40 or above and, due to the pannus, has uncontrollable infections or medical complications, e.g., hernia, **or**
- b. Has had gastric bypass or gastric stapling with subsequent weight loss and the resulting pannus significantly interferes with mobility or is the site of uncontrollable inflammation and/or infection or otherwise complicates medical conditions, e.g., hernia.

Uncontrollable infections are those that are recurrent, severe intertrigo/cellulitis that require treatment with an oral antibiotic and are unresponsive to conservative treatment including adequate hygiene and topical anti-infective medications.

### 4.0 When the Procedure Is Not Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

Panniculectomy is not covered when the medical necessity criteria listed in **Section 3.0** are not met or when performed for solely cosmetic purposes.

Difficulty in fitting clothes is not considered a criterion for panniculectomy.

## **5.0 Requirements for and Limitations on Coverage**

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### **5.1 Prior Approval**

The following information must be submitted with the prior approval request:

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

### **5.2 Limitation to Service**

This service is limited to once per lifetime.

## **6.0 Providers Eligible to Bill for the Procedure**

Physicians enrolled in the N.C. Medicaid program who perform this procedure may bill for this procedure.

## **7.0 Additional Requirements**

There are no additional requirements.

## 8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

### 8.1 Claim Type

Physicians bill professional services on the CMS-1500 claim form.

### 8.2 Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

### 8.3 Procedure Codes

The CPT code covered by the N.C. Medicaid program is **15831**.

The CPT procedure code listed above is subject to the multiple surgery guidelines.

### 8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

## 9.0 Policy Implementation/Revision Information

**Original Effective Date:** May 1, 1988

### Revision Information:

Date	Section Revised	Change
9/1/04	Section 3.0	Added age restriction
9/1/04	Section 3.0	Changed weight requirement to BMI of 40 or above from in excess of 100 pounds
9/1/04	Section 3.0	Changed requirement that recipient be "insulin dependent with a serious infection control problem <b>AND</b> the pannus must be causing prolapse of a ventral hernia" to recipient "has a BMI of 40 or above and, due to the pannus, has uncontrollable infections or medical complications, e.g., hernia" <b>OR</b> "has had gastric bypass or gastric stapling with subsequent weight loss and the resulting pannus significantly interferes with mobility or is the site of uncontrollable inflammation and/or infection or otherwise complicates medical conditions, e.g., hernia."
9/1/04	Section 3.0	Defined uncontrollable infections
9/1/04	Section 4.0	Added "Difficulty in fitting clothes is not considered a criterion for Panniculectomy."
9/1/04	Section 5.1	Delineated specifications for documentation
9/1/04	Section 5.2	Added once per lifetime limitation.
9/1/05	Section 2.0	A special provision related to EPSDT was added.

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
10/1/10	Throughout	Service Eliminated Due to 2010 Budget Reduction
10/4/10	Throughout	End Dated version of policy for archive