

PANNICULECTOMY AND BODY CONTOURING PROCEDURES

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Related Policies

- [Breast Reconstruction Post Mastectomy](#)
- [Cosmetic and Reconstructive Services](#)

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

CONDITIONS OF COVERAGE

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General benefits package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes ^{1,2}
Precertification with Medical Director Review Required	Yes ^{1,2}
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	All
Special Considerations	¹ Precertification with review by a Medical Director or their designee is required. ² Precertification is required for services covered under the Member's General Benefits package when performed in the office of a participating provider. For Commercial plans, precertification is not required, but is encouraged for out-of-network services performed in the office that are covered under the Member's General Benefits package. If precertification is not obtained, Oxford may review for medical necessity after the service is rendered.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Indications for Coverage

Panniculectomy

Panniculectomy is considered reconstructive and medically necessary when ALL of the following criteria have been met:

- Panniculus must hang below symphysis pubis;
- The Panniculus is the primary cause of skin conditions when present, such as cellulitis requiring systemic antibiotics or transdermal skin ulcerations that require medical treatment;
- There is presence of a Functional Impairment (interference with activities of daily living) due to the Panniculus;
- The surgery is expected to restore or improve the Functional Impairment.

Notes:

- After significant weight loss unrelated to bariatric surgery, in addition to the criteria listed above, there must be documentation that a stable weight has been maintained for six months.
- After significant weight loss following bariatric surgery, in addition to meeting the criteria listed above, there must be documentation that a stable weight has been maintained for six months. This often occurs 12-18 months after surgery.

Panniculectomy is not considered reconstructive or medically necessary, in the following situations (not an all-inclusive list):

- When performed to relieve neck or back pain as there is no evidence that reduction of redundant skin and tissue results in less spinal stress or improved posture/alignment.
- When performed in conjunction with abdominal or gynecologic surgery including but not limited to hernia repair, obesity surgery, C-section and hysterectomy unless the member meets the criteria for Panniculectomy as stated above in this document.
- Performed post childbirth in order to return to pre pregnancy shape.
- Performed for intertrigo, a superficial inflammatory response or any other condition that does not meet the criteria above in this document.

Documentation may be requested as part of the review, including but not limited to photographs and physician office notes.

Abdominoplasty

Abdominoplasty is not considered reconstructive or medically necessary. Repair of Diastasis Recti is considered a cosmetic procedure, and is not a covered service.

Lipectomy

Lipectomy is not considered reconstructive or medically necessary, in the following situation (not an all-inclusive list): Performed on any site including buttocks, arms, legs, neck, abdomen and medial thigh.

Suction-Assisted Lipectomy of the Trunk

Suction-assisted lipectomy of the trunk (CPT code 15877) is not considered reconstructive (unless part of an approved procedure) or medically necessary.

For post-mastectomy patients, please refer to the Oxford policy [Breast Reconstruction Post Mastectomy](#).

Coverage Limitations and Exclusions

Some states require benefit coverage for services that Oxford Health Plans considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please refer to the member specific benefit plan document.

- Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.
- Any procedure that does not meet the reconstructive criteria above in the [Indications for Coverage](#) section.

DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Abdominoplasty: Typically performed for cosmetic purposes, involves the removal of excess skin and fat from the pubis to the umbilicus or above, and may include fascial plication of the rectus muscle diastasis and a neoumbilicoplasty.

Belt Lipectomy: A circumferential procedure which combines the elements of an Abdominoplasty or Panniculectomy with removal of excess skin/fat from the lateral thighs and buttock. The procedure involves removing a "belt" of tissue from around the circumference of the lower trunk which eliminates lower back rolls, and provides some elevation of the outer thighs, buttocks, and mons pubis. Similarly, a Circumferential Lipectomy describes an Abdominoplasty or Panniculectomy combined with flank and back lifts.

Circumferential Lipectomy: Combines an Abdominoplasty with a "back lift", both procedures being performed together sequentially and including suction assisted lipectomy, where necessary.

Diastasis Recti: A thinning of the linea alba in the epigastrium and is manifested as a smooth midline protrusion of the anterior abdominal wall. The transversalis fascia is intact, and hence this is not a hernia. There are no identifiable fascial margins and no risk for intestinal strangulation. The presence of diastasis recti may be particularly noticeable to the patient on straining or when lifting the head from the pillow. Appropriate treatment consists of reassurance of the patient and family about the innocuous nature of this condition.

Functional/Physical Impairment: A Physical/Functional or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Liposuction Suction-Assisted Lipectomy: Suction-assisted lipectomy (SAL), traditionally known as liposuction, is a method of removing unwanted fatty deposits from specific areas of the face and body. The surgeon makes a small incision and inserts a cannula attached to a vacuum device that suctions out the fat. Areas suitable for liposuction include the chin, neck, cheeks, upper arms, area above the breasts, the abdomen, flanks, the buttocks, hips, thighs, knees, calves and ankles. Liposuction can improve body contour and provide a sleeker appearance. Surgeons may also use liposuction to remove lipomas (benign fatty tumors) in some cases.

Lower Body Lift: A procedure that treats the lower trunk and thighs as a unit by eliminating a circumferential wedge of tissue that is generally, but not always, more inferiorly positioned laterally and posteriorly than a Belt Lipectomy.

Mini or Modified Abdominoplasty: Typically performed on patients with a minimal to moderate defect as well as mild to moderate skin laxity and muscle flaccidity and do not usually involve muscle plication above the umbilical level or neoumbilicoplasty.

Panniculectomy: Involves the removal of hanging excess skin/fat in a transverse or vertical wedge but does not include muscle plication, neoumbilicoplasty or flap elevation. A cosmetic Abdominoplasty is sometimes performed at the time of a functional Panniculectomy.

Panniculus: A medical term describing a dense layer of fatty tissue growth, usually in the abdominal cavity. It can be a result of morbid obesity and can be mistaken for a tumor or hernia.

Sickness: Physical illness, disease or pregnancy. The term Sickness does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

Torsoplasty: Is a series of operative procedures, usually done together to improve the contour of the torso, usually female (though not exclusively). This series would include Abdominoplasty with liposuction of the hips/flanks and breast augmentation and/or breast lift/reduction. In men, this could include reduction of gynecomastia by suction assisted lipectomy/ultrasound assisted lipectomy or excision.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

CPT Code	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

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REFERENCES

The foregoing Oxford policy has been adapted from an existing Coverage Determination Guideline (CDG) that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee. [CDG.014.09]

Capon A. Body reshaping surgery after massive weight loss. J Visc Surg. 2010 Oct;147 (5 Suppl): e53-64. doi: 10.1016/j.jviscsurg.2010.08.008.

CMS Novitas Solutions, Inc. Cosmetic and Reconstructive Surgery. (LCD L35090): Accessed September 18, 2017.

MCG™ Care Guidelines, 22nd edition, 2018. Panniculectomy ACG: A-0498 (AC).

Townsend CM, Beauchamp RD, Evers BM, et al. Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice. 20th ed. Elsevier Inc. 2017. Chapter 68, Body Contouring After Bariatric Surgery; p. 1938-1974.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
04/01/2018	<ul style="list-style-type: none"> Updated supporting information; replaced reference to "MCG™ Care Guidelines, 21st edition, 2017" with "MCG™ Care Guidelines, 22nd edition, 2018" Archived previous policy version SURGERY 038.22 T2