Clinical Policy: Abdominoplasty, Panniculectomy, Suction Lipectomy, and Lipoabdominoplasty

Reference Number: IL.CP.MP.510 Coding Implications
Last Review Date: 03/21 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following guidelines address MHP coverage for procedures performed to either remove tighten or repair excess skin and or subcutaneous tissue in the truncal region. According to the American Society of Plastic and Reconstructive Surgeons, the specialty of plastic surgery includes reconstructive and cosmetic procedures:

1. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involutional defects, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.
2. Cosmetic surgery is primarilyperformed to reshape normal structures of the body to improve the patient's appearance and self-esteem, with little to no impact on function.

Definition:
Panniculectomy is a surgical procedure to remove an abdominal pannus or panniculus. A panniculus is formed secondary to obesity when there is a dense layer of fatty tissue growth on the abdomen that becomes large enough to hang down from the body. Panniculus size varies from grade 1, which reaches the mons pubis, to grade 5, which extends to or reaches past the knees.

Abdominoplasty is a surgical procedure that tightens the lax anterior abdominal wall muscles and trims excess adipose tissue and skin. Panniculectomy differs from abdominoplasty in the sense that abdominoplasty is usually performed as a cosmetic procedure to improve appearance but not function.

Policy/Criteria
I. It is the policy of MeridianHealth affiliated with Centene Corporation® that a Panniculectomy or Abdominoplasty is **medically necessary** for the following indications:
   A. **Panniculectomy:** The panniculus hangs below the level of the pubis, documented by photographs **and one** of the following:
      i. The member's treating physician must document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over 6 months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of 3 months.
      ii. Excision of excessive skin and subcutaneous tissue (including Lipectomy) of the abdomen (Abdominoplasty) (15830) will only be considered reasonable and medically necessary when these procedures are performed in conjunction with an abdominal surgery being done at the same time and

allowing the tissue to remain would affect the healing of the surgical incision.

iii. This procedure may also be considered to be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity and there are medical complications such as candidiasis, intertrigo or tissue necrosis that is unresponsive to oral or topical medication or physical aids.
    a. If the procedure is being performed for intertrigo, consultation with a dermatologist must be present.

iv. If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six months.

v. If the weight loss has occurred as a result of bariatric surgery, Abdominoplasty/Panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months.

MHP considers Panniculectomy cosmetic when these criteria are not met.

B. **Abdominoplasty:** Excision of excessive skin and subcutaneous tissue (including lipectomy of the abdomen) is medically necessary according to the following criteria:
    i. When these procedures are performed in conjunction with an abdominal surgery being done at the same time and allowing the tissue to remain would affect the healing of the surgical incision.
    ii. This procedure may also be considered to be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity and there are medical complications such as candidiasis, intertrigo or tissue necrosis that is unresponsive to oral or topical medication or physical aids that consistently recurs over 6 months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of 3 months.
        a. If the procedure is being performed for intertrigo, consultation with a dermatologist must be present.

C. **Suction Lipectomy/Lipoabdominoplasty:**
    i. Meridian considers suction lipectomy and lipoabdominoplasty to be cosmetic in nature because they are not associated with functional improvememnts. Therefore, the are not medically necessary.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		11/19/10

References

1. American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Surgical Treatment of Skin Redundancy Following Massive Weight Loss. Revision Date: January, 2007..
2. American Society of Plastic Surgeons (ASPS). Practice Advisory on Liposuction. Executive Summary. 2003 Mar.
3. Chaouat M, Levan P, Lalanne B, Buisson T, Nicholau P, Mimoun M. Abdominal dermolipectomies: early postoperative complications and long-term unfavorable results. Plast Reconstr Surg. 2000 Dec; 106(7):1614-8; discussion 1619-23.
4. Nahas FX, Augusto SM, Ghelfond C. Should diastasis recti be corrected? Aesthetic Plast Surg. 1997 Jul-Aug; 21(4):285-9.
5. Guidelines from the Board of Governors of the Society of American Gastrointestinal and Endoscopic Surgeons. August 2014
6. Surg Endosc. 2014; 28(1): 2-29
7. Hayes medical Technology Directory, May 19, 2016

8. Panniculectomy for treatment of symptomatic panniculi. Lnadsdale, PA: Hayes, Inc © 2012 Winifred S. Hayes, Inc. Annual review: June 12, 2019
9. Centene Corporation Clinical Policy: Panniculectomy, Reference Number CP.MP.109
10. State of Illinois Contract between the Department of Healthcare and Family Services and Meridian Health Plan of Illinois, 2018-24-601, Preauthorization and Concurrent Review Requirements, 1.1.2.3.3

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.