

PANNICULECTOMY AND BODY CONTOURING PROCEDURES

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[Instructions for Use](#) ⓘ

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COVERAGE RATIONALE

Indications for Coverage

Panniculectomy

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

- Panniculus hangs at or 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

Note:

- 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, and is not a covered service, 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, and is not a covered service. Repair of Diastasis Recti is considered a Cosmetic Procedure, and is not a covered service.

Lipectomy

Lipectomy is not considered reconstructive, and is not a covered service, 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), and is not a covered service.

For post-mastectomy members, refer to the Coverage Determination Guideline titled [Breast Reconstruction Post Mastectomy](#).

Coverage Limitations and Exclusions

Some states require benefit coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please refer to 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 neumbilicoplasty.

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.

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Cosmetic Procedures (California only): Procedures or services that are performed to alter or reshape normal structures of the body in order to improve your appearance.

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 or Physical or Physiological Impairment: A Functional or Physical 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.

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition
- Improvement or restoration of physiologic function

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you 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.

Reconstructive Procedures (California only): Reconstructive Procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- To improve function
- To create a normal appearance, to the extent possible

Reconstructive Procedures include surgery or other procedures which are related to a health condition. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Care Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Sickness: Physical illness, disease or Pregnancy. The term Sickness includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Torsoplasty: 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 guideline 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 and Coverage Determination Guidelines may apply.

| CPT Code | Description |
|---|---|
| The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive. | |
| 15830 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy |

| CPT Code | Description |
|--|--|
| The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive. | |
| 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) |
| 15877 | Suction assisted lipectomy; trunk |
| The following codes are considered cosmetic; the codes do not improve a functional, physical or physiological impairment. | |
| 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 |
| 15876 | Suction assisted lipectomy; head and neck |
| 15878 | Suction assisted lipectomy; upper extremity |
| 15879 | Suction assisted lipectomy; lower extremity |

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REFERENCES

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CMS Novitas Solutions, Inc. [Cosmetic and Reconstructive Surgery. \(LCD L35090\)](#). Accessed February 11, 2019.

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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.

GUIDELINE HISTORY/REVISION INFORMATION

| Date | Action/Description |
|------------|--|
| 04/01/2019 | <ul style="list-style-type: none"> • Reorganized policy template: <ul style="list-style-type: none"> ○ Simplified and relocated <i>Instructions for Use</i> ○ Removed <i>Benefit Considerations</i> section • Updated coverage rationale; replaced reference to “patients” with “members” • Updated definitions: <ul style="list-style-type: none"> ○ Removed definition of “Congenital Anomaly (California only)” ○ Modified definition of: <ul style="list-style-type: none"> ▪ Cosmetic Procedures (California only) ▪ Reconstructive Procedures (California only) • Updated list of applicable CPT codes; added language to clarify: <ul style="list-style-type: none"> ○ 15830, 15847, and 15877 may be cosmetic; review is required to determine if [the service is] considered cosmetic or reconstructive ○ 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15878, and 15879 are considered cosmetic; the codes do not improve a functional, physical or physiological impairment • Updated supporting information; replaced reference to “MCG™ Care Guidelines, 22nd edition, 2018” with “MCG™ Care Guidelines, 23rd edition, 2019” • Archived previous policy version CDG.014.11 |

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Coverage Determination 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.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.