Panniculectomy Surgery

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➲ Instructions for Use

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Related Community Plan Policies

- Breast Reconstruction
- Cosmetic and Reconstructive Procedures
- Gender Dysphoria Treatment
- Liposuction for Lipedema
- Omnibus Codes

Commercial Policy

- Panniculectomy Surgery

Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Idaho	Panniculectomy and Body Contouring Procedures (for Idaho Only)
Indiana	None
Kansas	Panniculectomy Surgery (for Kansas Only)
Kentucky	Panniculectomy and Body Contouring Procedures (for Kentucky Only)
Louisiana	Panniculectomy and Body Contouring Procedures (for Louisiana Only)
Nebraska	Panniculectomy Surgery (for Nebraska Only)
New Jersey	Panniculectomy Surgery (for New Jersey Only)
New Mexico	Panniculectomy Surgery (for New Mexico Only)
North Carolina	Panniculectomy Surgery (for North Carolina Only)
Ohio	Panniculectomy and Body Contouring Procedures (for Ohio Only)
Pennsylvania	Panniculectomy Surgery (for Pennsylvania Only)
Tennessee	Panniculectomy Surgery (for Tennessee Only)

Coverage Rationale

Panniculectomy

Panniculectomy is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Panniculectomy, Abdominal.

Click here to view the InterQual® criteria.

Panniculectomy is considered cosmetic and not medically necessary when performed for the following indications:

- For any other condition that does not meet the InterQual® criteria

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- In conjunction with abdominal or gynecologic surgery, including but not limited to hernia repair, bariatric surgery, C-section, or hysterectomy, unless the member meets the InterQual® CP: Procedures, Panniculectomy, Abdominal criteria
- When performed for primarily cosmetic purposes

Notes:
- For information on liposuction for lipedema, refer to the Medical Policy titled Liposuction for Lipedema.
- For information on liposuction when being performed post-mastectomy, refer to the Medical Policy titled Breast Reconstruction.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews.

Definitions

Check the definitions within the federal, state, or contractual requirements that supersede the definitions below.

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 (ASPS, 2017).

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 federal, state, or contractual requirements 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 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
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
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

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Description of Services

An abdominal panniculus is an apron of skin and fat that hangs down from the abdomen. This often occurs following massive weight loss and can lead to skin infections, rashes, and difficulty completing activities of daily living (Sachs et al., 2021). A Panniculectomy is a surgery that removes this excess skin and fat but typically does not involve the abdominal muscles (ASPS, 2017).

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Clinical Evidence

Panniculectomy

There is insufficient quality evidence to conclude that panniculectomy performed in conjunction with abdominal or gynecological surgery, including, but not limited to, hernia repair, bariatric surgery, C-section, or hysterectomy, outweighs negative outcomes. Additional peer-reviewed literature is needed to determine long-term benefits and impact on surgical complications and recovery when panniculectomy is performed concurrently.

Elhage et al. (2021) evaluated the outcomes and quality of life (QOL) in patients undergoing complex abdominal wall reconstruction (AWR) with panniculectomy utilizing 3D volumetric-based propensity match in a prospective cohort study. A prospective database from a tertiary referral hernia center was queried for patients undergoing open AWR. 3D CT volumetrics were analyzed and a propensity match comparing AWR patients with and without panniculectomy was created including subcutaneous fat volume (SFV). QOL was analyzed using the Carolinas Comfort Scale. Propensity match yielded 312 pairs, all with adequate CT imaging for volumetric analysis. The panniculectomy group had a higher BMI ($p = 0.03$) and were more likely female ($p < 0.0001$), but all other demographics and comorbidities were similar. The panniculectomy group was more likely to have undergone prior hernia repair (77% vs. 64%, $p < 0.001$), but hernia area, SFV, and CDC wound class were similar (all $p > 0.05$). Requirement of component separation (61% vs. 50%, $p = 0.01$) and mesh excision (44% vs. 35%, $p = 0.02$) were higher in the panniculectomy group, but operative time were similar (all $p \geq 0.05$). Panniculectomy patients had a higher overall wound occurrence rate (45% vs. 32%, $p = 0.002$) which was differentiated only by a higher rate of wound breakdown (24% vs. 14%, $p = 0.003$); all other specific wound complications were equal (all $p \geq 0.05$). Hernia recurrence rates were similar (8% vs. 9%, $p = 0.65$) with an average follow-up of 28 months. Overall QOL was equal at 2 weeks, and 1, 6, and 12 months (all $p \geq 0.05$). The authors concluded that despite panniculectomy patients and their hernias being more complex, concomitant panniculectomy increased wound complications but did not negatively impact infection rates or long-term outcomes and recommended concomitant panniculectomy be considered in appropriate patients to avoid two procedures.

In a retrospective cohort study, Gebran et al. (2021) evaluated the risk profile of panniculectomy when performed in select patients at the time of bariatric surgery. The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) database (2016-2017), in which data on 379,544 bariatric surgeries were reported was examined. Concurrent panniculectomy procedures were identified by Current Procedural Technology (CPT) codes. Patient characteristics and in-hospital as well as 30-day complications were compared between the body contouring group and propensity score-matched bariatric surgery controls. One hundred twenty-four patients met inclusion criteria and were matched to 248 controls. An infra-umbilical panniculectomy was performed in the majority of patients (n = 94, 75.8%). Most patients received an open rather than laparoscopic bariatric surgery (n = 87, 70.2%). There were no statistically significant differences between 30-day mortality (1.9%), wound complications (11.5%), readmission (12.5%) and reoperation (5.8%) between the 2 groups ($p > .05$). Wound complications occurred in 11.5% of patients and were associated with prolonged hospital stay (odds ratio 4.65, 95% confidence interval 1.99-10.86, $p < .001$) and a body mass index (BMI) > 50 (odds ratio 3.19, 95% confidence interval 1.02-9.96, $p = .046$). The authors concluded, in select patients, panniculectomy at the time of bariatric surgery was not associated with increased in-hospital or 30-day adverse outcomes compared with matched bariatric surgery controls, however, revision surgery may be needed once weight loss stabilizes. The study was limited by database limitations, short-term follow up, and multiple outcome variables.

Nag et al. (2021) performed a retrospective cohort study and systematic review to evaluate the premise that the addition of panniculectomy to gynecologic surgery in the obese and morbidly obese patient population results in a statistically significant improvement in measurable outcomes. The American College of Surgeons National Surgical Quality Improvement Program (NSQIP) database was reviewed to assess the association of complications with panniculectomy combined with gynecologic surgery in the morbidly obese patient population. The query identified 296 patients with a BMI greater than 30 who had panniculectomy concomitant with gynecologic surgery. The results demonstrated a statistically significant relationship ($p < 0.05$) of these concomitant procedures with superficial infection, wound infection, pulmonary embolism, systemic sepsis, return to operating room, length of operation and length of stay. A systematic review of the literature was then performed which identified only 5 studies that included comparative cohorts of those with gynecologic surgery, with and without panniculectomy. There was no significant benefit across the studies in measured parameters. The authors concluded that there was no statistically significant benefit associated with performing panniculectomy in conjunction with gynecologic surgery in the morbidly obese patient population and that there was significant elevation of negative outcomes in morbidly obese patients undergoing combined procedures.

In a systematic meta-analysis, Prodromidou et al. (2020) assessed the current knowledge concerning the safety and efficacy of combining panniculectomy in surgical management of endometrial cancer (EC) in obese patients. Four electronic databases were systematically searched for articles published up to May 2019. A total of five studies, of which

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two were non-comparative and three comparative, were included. Meta-analysis of complications among panniculectomy and conventional laparotomy group revealed no difference in either intra- or post-operative complication rates. Moreover, no difference was reported in surgical site complications (p = 0.59), while wound breakdown rates were significantly elevated in the laparotomy group (p = 0.02). The authors concluded panniculectomy combined surgery for the management of EC can be considered a safe procedure in selected patients and presents with comparable outcomes to conventional laparotomy procedures with regard to non-surgical and surgical site complications and improved wound breakdown rates. The authors noted that the outcomes must be cautiously interpreted because of the limited number of studies included in this meta-analysis and their retrospective nature.

Sosin et al. (2020) conducted a systematic meta-analysis to assess the durability, complication profile, and safety of simultaneous ventral hernia repair and panniculectomy (SVHRP) through a large data-driven repository of SVHRP cases. The current SVHRP literature was queried using the MEDLINE, PubMed, and Cochrane databases. Predefined selection criteria resulted in 76 relevant titles yielding 16 articles for analysis. Meta-analysis was used to analyze primary outcomes, identified as surgical-site occurrence and hernia recurrence. Secondary outcomes included review of techniques used and systemic complications, which were analyzed with pooled weighted mean analysis from the collected data. There were 917 patients who underwent an SVHRP (mean age, 52.2 ±7.0 years; mean BMI, 36.1 ±5.8 kg/m; mean pannus weight, 3.2 kg). The mean surgical-site occurrence rate was 27.9% (95% CI, 15.6 to 40.2%; I = 70.9%) and the mean hernia recurrence rate was 4.9% (95% CI, 2.4 to 7.3%; I = 70.1%). Mean follow-up was 17.8 ±7.7 months. The most common complications were superficial surgical-site infection (15.8%) and seroma formation (11.2%). Systemic complications were less common (7.8%), with a thromboembolic event rate of 1.2%. The overall mortality rate was 0.4%. The authors concluded SVHRP is associated with a high rate of surgical-site occurrence, but surgical-site infection seems to be less prominent than previously anticipated. The authors indicated the low hernia recurrence rate, and the safety of this procedure support its current implementation in abdominal wall reconstruction. (McNichols et al., 2018 is included in this review.)

In a retrospective cohort study, Diaconu et al. (2019) compared outcomes in obese patients who undergo ventral hernia repair with concurrent panniculectomy versus ventral hernia repair alone. Postoperative complications were compared between patient who underwent concurrent panniculectomy and those who did not. A total of 223 patients were analyzed: 122 in the ventral hernia repair with concurrent panniculectomy group and 101 in the ventral hernia repair-only group. Median follow-up duration was 141 days. Patients in the ventral hernia repair with concurrent panniculectomy group had more surgical-site occurrences (57 percent versus 40 percent; p = 0.012). Both groups had similar rates of surgical-site occurrences that required an intervention (39 percent versus 31 percent; p = 0.179) and similar rates of hernia recurrence (23 percent versus 29 percent; p = 0.326). Multivariate analysis showed that concurrent panniculectomy increased the risk of surgical-site occurrences by two-fold; however, it did not increase the risk of surgical-site occurrences that required an intervention. The authors concluded the addition of a panniculectomy to ventral hernia repair increases surgical-site occurrences but does not increase complications that require an intervention.

Clinical Practice Guidelines

American Society of Plastic Surgeons (ASPS)

In a practice parameter, ASPS (2017) noted panniculectomy could be considered as a functional correction in patients who are of appropriate height and weight, and have a history of problems including panniculitis or chronic back pain that have persisted despite an adequate trial of non-surgical management, or have a functional impairment in activities of daily living/work, etc. ASPS notes a strong relationship between increased BMI and surgical complication across the surgical spectrum.

Society of Obstetricians and Gynaecologists of Canada (SOGC)

SOGC clinical practice guideline for gynecologic surgery for patients with obesity (Yong et al., 2019) reviews the evidence for panniculectomy performed concurrently with gynecologic surgeries. The guideline notes that studies in this area have been primarily small, retrospective, and/or non-comparative studies. The authors indicated that panniculectomy can be considered at the time of open hysterectomy in patients with obesity, although it is rarely performed; and when a combined procedure is done, consideration should be given to postoperative antibiotics.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Panniculectomy procedures are not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed February 13, 2025)

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Policy History/Revision Information

Date	Summary of Changes

11/01/2025	**Title Change**
	• Previously titled *Panniculectomy and Body Contouring Procedures*
	Coverage Rationale
	• Removed language indicating body contouring procedures, including but not limited to the following, are considered cosmetic and not medically necessary:
	  ○ Abdominoplasty
	  ○ Lipectomy, including suction-assisted lipectomy (unless part of an approved procedure)
	  ○ Repair of diastasis recti
	• Updated instruction to refer to the Medical Policy titled *Breast Reconstruction for information on liposuction when being performed* post-mastectomy
	Definitions
	• Removed definition of:
	  ○ Abdominoplasty
	  ○ Diastasis Recti
	  ○ Functional or Physical or Physiological Impairment
	  ○ Suction Assisted Lipectomy
	Applicable Codes
	• Removed CPT codes 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, and 15876
	Supporting Information
	• Updated *Description of Services, Clinical Evidence, FDA*, and *References* sections to reflect the most current information
	• Archived previous policy version CS093.W

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Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies 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.

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