

# Panniculectomy and Body Contouring Procedures (for Ohio Only)

Guideline Number: CS093OH.S – P  
Effective Date: February 1, 2023

[➔ Instructions for Use](#)

Table of Contents	Page
<a href="#">Application</a> .....	1
<a href="#">Coverage Rationale</a> .....	1
<a href="#">Definitions</a> .....	2
<a href="#">Applicable Codes</a> .....	4
<a href="#">References</a> .....	4
<a href="#">Guideline History/Revision Information</a> .....	4
<a href="#">Instructions for Use</a> .....	5

Related Policies
• <a href="#">Breast Reconstruction Post Mastectomy and Poland Syndrome (for Ohio Only)</a>
• <a href="#">Cosmetic and Reconstructive Procedures (for Ohio Only)</a>
• <a href="#">Omnibus Codes (for Ohio Only)</a>

## Application

This Coverage Determination Guideline only applies to the state of Ohio.

## Coverage Rationale

### Indications for Coverage

The following are eligible for coverage when the below criteria are met.

Panniculectomy when all of the following criteria have been met:

- Panniculus hangs at or below symphysis pubis
- The Panniculus, when present, is the primary cause of skin conditions 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.

The following are not considered reconstructive and are not covered services:

- Abdominoplasty
- Lipectomy when performed on any site including (not an all-inclusive list):
  - Abdomen
  - Arms
  - Buttocks
  - Legs
  - Medial thigh

- Neck
- Trunk
- Panniculectomy (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 (not an all-inclusive list):
    - 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
    - Superficial inflammatory response
    - Any other condition that does not meet the criteria above in this document
- Repair of Diastasis Recti
- Suction-assisted lipectomy (unless part of an approved procedure). For post-mastectomy, refer to the Coverage Determination Guideline titled [Breast Reconstruction Post Mastectomy and Poland Syndrome \(for Ohio Only\)](#).

## Documentation Requirements

Medical notes documenting the following, when applicable:

- Primary complaint, history of complaint and physical exam
- Intertriginous rashes or other skin problems with documentation of treatment and response
- Functional limitations due to pannus
- High-quality color photographs. (For panniculectomy, photographs of a full-frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows any skin damage to be evaluated, and a full-lateral view of the hanging pannus.)
  - Note: All photographs must be labeled with the:
    - Date taken
    - Applicable case number obtained at time of notification, or the member’s name and ID number on the photographs
  - Photographs can be submitted via the external portal at [www.uhcprovider.com/paan](http://www.uhcprovider.com/paan); faxes will not be accepted

## Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- 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.
- Procedures that do not meet the reconstructive criteria in the [Indications for Coverage](#) section.
- For liposuction for the treatment of lipedema, refer to the Medical Policy titled [Omnibus Codes \(for Ohio Only\)](#).

## Definitions

Check the definitions within the member specific benefit plan document that supersede the definitions below.

**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.

**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.

**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.

**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 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
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

*CPT® is a registered trademark of the American Medical Association*

## References

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

CMS Novitas Solutions, Inc. [Cosmetic and Reconstructive Surgery \(LCD L35090\)](#). Accessed September 21, 2021.

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

## Guideline History/Revision Information

Date	Summary of Changes
02/01/2023	<ul style="list-style-type: none"> <li>Created state-specific policy version</li> </ul>

Date	Summary of Changes
12/1/2021	<p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>● Removed notation indicating documentation may be requested as part of the review, including but not limited to photographs and physician office notes (refer to the <i>Documentation Requirements</i> section of the policy)</li> <li>● Updated documentation requirements; replaced criterion requiring: <ul style="list-style-type: none"> <li>○ “High quality color photographs of a full frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows any skin damage can be evaluated, and a full-lateral view of the hanging pannus” with “high quality color photographs; <i>for Panniculectomy, photographs</i> of a full frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows any skin damage can be evaluated, and a full-lateral view of the hanging pannus”</li> <li>○ “<i>Submission of diagnostic photographs is required</i> via the external portal” with “diagnostic photographs <i>can be submitted</i> via the external portal”</li> </ul> </li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>● Updated <i>References</i> section to reflect the most current information</li> <li>● Archived previous policy version CS093.R</li> </ul>

## Instructions for Use

This Coverage Determination Guideline 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 guideline, 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 Coverage Determination Guideline 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 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.