

# Panniculectomy and Body Contouring Procedures

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[Instructions for Use](#)

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Related Medical Management Guidelines
<ul style="list-style-type: none"> <li><a href="#">Breast Reconstruction Post Mastectomy and Poland Syndrome</a></li> <li><a href="#">Cosmetic and Reconstructive Procedures</a></li> <li><a href="#">Omnibus Codes</a></li> </ul>
Related Benefit Interpretation Policy
<ul style="list-style-type: none"> <li>Cosmetic, Reconstructive, or Plastic Surgery</li> </ul>

## 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.

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.

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 Medical Management Guideline titled [Breast Reconstruction Post Mastectomy and Poland Syndrome](#).

## Coverage Limitations and Exclusions

UnitedHealthcare West excludes Cosmetic Services and Surgery from coverage including but not limited to the following:

- Services and Surgery that correct an anatomical Congenital Defect without improving or restoring physiologic function are considered Cosmetic Services and Surgery. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or Congenital Defect 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 Management Guideline titled [Omnibus Codes](#).

## Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

### Required Clinical Information

#### Panniculectomy and Body Contouring Procedures

Medical notes documenting all of the following:

- 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 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; all photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s)

Note: S[ubmission of color photos can be submitted via the external portal at [www.uhcprovider.com/paan](http://www.uhcprovider.com/paan) or via email at [CCR@uhc.com](mailto:CCR@uhc.com); faxes of color photos will not be accepted.

## 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.

**Congenital Defect:** A condition that is present at birth.

**Cosmetic Services and Surgery (California Only):** Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance.

**Cosmetic Services and Surgery (WA, OR, TX, and OK Only):** Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance, as influenced by that Member's underlying psychological makeup or psychiatric condition.

**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 Physical or Functional or Physiological Impairment causes deviation from the normal function of a tissue or organ. These 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 Surgery:** Reconstructive Surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of Reconstructive Surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible.

**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 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

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## References

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 May 26, 2020.

MCG™ Care Guidelines, 24th edition, 2020, 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.

## Guideline History/Revision Information

Date	Summary of Changes
01/01/2021	<b>Template Update</b> <ul style="list-style-type: none"><li>Reformatted policy; transferred content to new template</li></ul>
11/01/2020	<b>Coverage Rationale</b> <ul style="list-style-type: none"><li>Clarified coverage criteria for Panniculectomy; replaced criterion requiring “the Panniculus is the primary cause of skin conditions, <i>when present</i>” with “the Panniculus, <i>when present</i>, is the primary cause of skin conditions”</li><li>Updated list of reconstructive/non-covered services; added “trunk” to the list of sites on which lipectomy is performed</li></ul> <b>Supporting Information</b> <ul style="list-style-type: none"><li>Archived previous policy version MMG100.Q</li></ul>

## Instructions for Use

This Medical Management 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 Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

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

Member benefit coverage and limitations may vary based on the member’s benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.