Panniculectomy and Body Contouring Procedures (for Indiana Only)

Policy Number: CS093IN.04
Effective Date: August 1, 2023

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Application

This Medical Policy only applies to the state of Indiana.

Coverage Rationale

For medical necessity clinical coverage criteria, refer to the Indiana Health Coverage Programs Provider Reference Module: Surgical Services.

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
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
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

CPT Code	Description
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)
*15876	Suction assisted lipectomy; head and neck
*15877	Suction assisted lipectomy; trunk
*15878	Suction assisted lipectomy; upper extremity
*15879	Suction assisted lipectomy; lower extremity

Note: Codes labeled with an asterisk (*) are not managed for medical necessity review for the state of Indiana at the time this policy became effective. Refer to the most up to date prior authorization list for Indiana at Prior Authorization and Notification: UnitedHealthcare Community Plan of Indiana.

References

Indiana Health Coverage Programs, Provider Reference Module. Surgical Services. Version6.0, April 2022. Available at: https://www.in.gov/medicaid/providers/files/surgical-services.pdf. Accessed March 31, 2023.

Policy History/Revision Information

Date	Summary of Changes
08/01/2023	**Applicable Codes** • Added CPT codes 15876, 15878, and 15879 · Added notation to indicate CPT codes 15876, 15878, and 15879 are not managed for medical necessity review for the state of Indiana at this time; refer to the most current *Prior Authorization and Notification List* for UnitedHealthcare Community Plan of Indiana **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version CS093IN.03

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, Care Guidelines, 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.