

# PANNICULECTOMY & BODY CONTOURING PROCEDURES

**Guideline Number:** CDG.014.02  
**Effective Date:** October 1, 2014

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## INSTRUCTIONS FOR USE

*This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs), and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee’s specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline 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. The MCG™ Care 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.*

## COVERAGE RATIONALE

### Plan Document Language

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

### **Essential Health Benefits for Individual and Small Group:**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee’s specific plan document to determine benefit coverage.

## **Requirements for Coverage**

### **Panniculectomy**

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

- a. Panniculus hangs at or below symphysis pubis;
- b. The panniculus causes a chronic and persistent skin condition (e.g., intertriginous dermatitis, cellulitis or transdermal skin ulcerations) that is refractory to at least three months of medical treatment and associated with at least one episode of cellulitis requiring systemic antibiotics. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics;
- c. There is presence of a functional impairment due to the panniculus;
- d. The surgery is expected to restore or improve the functional impairment;
- e. The panniculus is interfering with activities of daily living.

Note: After significant weight loss, in addition to the criteria listed above, there must be documentation that a stable weight has been maintained for six months. Panniculectomy after bariatric surgery, in addition to meeting the criteria listed above, should be delayed at least 18 months and there is documentation that a stable weight has been maintained for six months.

Panniculectomy is not considered reconstructive, and is not a covered service, in the following situations (*not an all-inclusive list*):

1. 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.
2. When performed in conjunction with abdominal or gynecologic surgery including but not limited to hernia repair, obesity surgery, C-section and hysterectomy unless the enrollee meets the criteria for panniculectomy as stated above in this document.
3. Performed post childbirth in order to return to pre pregnancy shape.
4. Performed for intertrigo, a superficial inflammatory response or any other condition that does not meet the criteria above in this document.

### **Abdominoplasty**

Abdominoplasty is not considered reconstructive, and is not a covered service, in the following situations (*not an all-inclusive list*):

1. Performed post childbirth in order to return to pre-pregnancy shape.
2. Performed for diastasis recti.
3. When performed in conjunction with abdominal or gynecologic surgery including but not limited to hernia repair, obesity surgery, C-section and hysterectomy.

4. No documentation of a physical and/or physiologic impairment.

### **Lipectomy**

Lipectomy is not considered reconstructive, and is not a covered service in the following situation (*not an all-inclusive list*):

1. 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 patients please refer to [Breast Reconstruction Post Mastectomy Coverage Determination Guideline](#)

### **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 enrollee's plan specific documents.

1. 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.
2. Any procedure that does not meet the reconstructive criteria above in the Indications for Coverage section

## **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:** Is 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. (2011 Generic COC)

**Congenital Anomaly (California Only):** A physical developmental defect that is present at birth

**Cosmetic Procedures:** Procedures or services that change or improve appearance without significantly improving physiological function, as determined by UHC. **(2011 Generic COC)**

**Cosmetic Procedures (California Only):** Procedures or services are performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance.

**Functional/Physical Impairment:** A physical/functional 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:** Is 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:** Is 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:** Is 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 to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with 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 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. (2011 Generic COC)

**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. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. 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.

**Sickness:** Physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

**Torsoplasty:** Is 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 codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit 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 claims payment. Other policies and coverage determination guidelines may apply.

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<b>Limited to specific procedure codes?</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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CPT <sup>®</sup> Procedure 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
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, 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

<b>Limited to specific diagnosis codes?</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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<b>Limited to place of service (POS)?</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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Limited to specific provider type?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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Limited to specific revenue codes?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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## REFERENCES

1. American Society of Plastic Surgeons (ASPS) available @: <http://www.plasticsurgery.org/>
2. MCG™ Care Guidelines, 18th edition, 2014. Panniculectomy ACG: A-0498 (AC).
3. CMS Novitas Solutions, Inc. Cosmetic and Reconstructive Surgery. (LCD 332763): <http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx>

## GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2014	<ul style="list-style-type: none"> <li>• Revised coverage rationale:               <ul style="list-style-type: none"> <li>○ Changed sub-header/title for “Indications for Coverage” to “Requirements for Coverage”</li> <li>○ Reorganized and clarified coverage criteria for panniculectomy                   <ul style="list-style-type: none"> <li>▪ Added language to indicate this procedure is considered reconstructive “and medically necessary” when noted criteria are met</li> <li>▪ Removed “Additional Information” pertaining to staging definitions for pressure ulcers</li> </ul> </li> <li>○ Removed content/language specific to ASO plan members</li> </ul> </li> <li>• Revised definitions:               <ul style="list-style-type: none"> <li>○ Removed language specific to the 2001 and 2007 generic Certificates of Coverage</li> </ul> </li> <li>• Removed definition of “mastopexy”</li> <li>• Archived previous policy version CDG.014.01</li> </ul>