BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Panniculectomy and Related Redundant Skin Surgery

Policy Number: OCA 3.722
Version Number: 16
Version Effective Date: 02/01/22

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan ☒ NH Medicaid ☒ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers panniculectomy to be **medically necessary** when Plan medical criteria are met. Prior authorization is required. Review the Plan's *Prior Authorization/Notification Requirements Matrix* and *Prior Authorization CPT Code Look-up Tools* for a list of services that require prior authorization or Plan notification. The Plan's prior authorization matrix, CPT/HCPCS code look-up tools, medical policies, and reimbursement policies are available at www.bmchp.org for BMC HealthNet Plan products and posted at www.wellsense.org for WellSense Health Plan products.

Clinical Criteria

A. Panniculectomy as a reconstructive procedure after weight loss or bariatric surgery is considered medically necessary when ALL criteria in items 1 through 8 are met and documented in the member's medical record:

1. The member is 18 years of age or older on the date of service; AND

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense New Hampshire Health Plan.

2. The surgery is expected to restore or improve the documented functional deficit; AND

3. The member's pannus hangs below the level of the pubis; AND

4. The member has maintained a stable weight for at least the most recent six (6) months when weight loss is secondary to lifestyle changes (including diet, exercise, and/or medical intervention without bariatric surgery) or for at least six (6) months post-surgery when the weight loss is the result of bariatric surgery; AND

5. If the member has had bariatric surgery, the member is at least 18 months post-operative since the bariatric surgery; AND

6. ANY condition listed in items a through c is documented in the member's medical record:

    a. Significant impaired physical function-interferes with normal activities of daily living; OR

    b. Severe lower back pain **directly caused by the member's pannus (hanging below the level of the pubus)** is interfering with activities of daily living (and all other etiologies for the associated pain are excluded and the severe lower back pain is refractory to conservative treatment); OR

    c. The pannus has resulted in ANY condition in items (1) through (5) and has not responded to appropriate medical treatment:

        (1) Cellulitis or panniculitis; OR

        (2) Recurrent or persistent skin infection under panniculus; OR

        (3) Intertriginous dermatitis (i.e., skin rashes in areas with skin folds which result in increased friction, temperature, and occlusion); OR

        (4) Non-healing skin ulceration under panniculus; OR

        (5) Skin maceration or skin necrosis of overhanging skin folds; AND

7. Documentation of failed treatment for at least 12 weeks with ANY of the medications or a combination of medications listed in items a through f under the direct supervision of a treating provider:

    a. Systematic antibiotics; OR

    b. Systematic antifungals; OR

c. Systemic corticosteroids; OR

d. Local or topical antibiotics; OR

e. Antifungals; OR

f. Corticosteroids; AND

8. Frontal and lateral preoperative high-quality color photographs may be requested by the Plan during the prior authorization process. Photos must be taken when the member is standing erect and must demonstrate the degree of the pannus and any related skin conditions.

B. The following procedures require Plan Medical Director review for individual consideration:

1. Abdominal liposuction or suction assisted lipectomy of the abdomen; OR

2. Abdominoplasty; OR

3. Mini abdominoplasty; OR

4. Repair of diastasis recti or abdominal laxity; OR

5. The surgical removal of redundant skin or body contouring, including brachioplasty, thighplasty and other body areas; OR

6. Additional procedure be performed simultaneously with the panniculectomy (e.g., abdominal, herniorrhaphy, or gynecological surgery).

Limitations and Exclusions

Liposuction is often an integral part of the surgical removal of excessive skin. Liposuction is NOT separately reimbursed when the member is authorized for panniculectomy.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 0130 and LCD L35090 include medically necessary indications for panniculectomy and related redundant skin surgery. Verify CMS guidelines in in effect on the date of the prior authorization request. When there is no guidance

from CMS on the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Code Covered When Medically Necessary
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy

CPT Codes	Description: Codes Considered Cosmetic and Not Medically Necessary
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 (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

References

American Association of Clinical Endocrinologists (AACE), The Obesity Society, and American Society for Metabolic and Bariatric Surgery (ASMBS). Mechanick JI, Youdim A, Jones DB, Garvey WT, Hurley DL, McMahon M, Heinberg LJ, Kushner R, Adams TD, Shikora S, Dixon JB, Brethauer S. Clinical practice guidelines for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient--2013 update: cosponsored by AACE, The Obesity Society, and American Society for Metabolic & Bariatric Surgery. Obesity (Silver Spring). 2013 Mar;21(0 1):S1–27. doi: 10.1002/oby.20461. PMID: 23529939.

Academy of Nutrition and Dietetics. Guideline Summaries.

Academy of Nutrition and Dietetics. Raynor HA, Champagne CM. Position of the Academy of Nutrition and Dietetics: Interventions for the Treatment of Overweight and Obesity in Adults. J Academy Nutri Diet. 2016 Jan;116(1):129-147. doi: 10.1016/j.jand.2015.10.031. PMID: 26718656.

American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third- Party Payers. Abdominoplasty. 2006 Jul. Posted in 2018.

American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third- Party Payers. Panniculectomy. 2006 Jul. Updated 2019 Jan.

American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third- Party Payers. Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. 2017 Jun.

Basta MN, Jehle CC, Fischer JP, Liu PY, Breuing KH. Abstract: Risk Stratification of Major Complications After Outpatient Abdominoplasty or Panniculectomy. Plast Reconstr Surg Glob Open. 2016 Sep 15;4(9 Suppl):79-80. doi: 10.1097/01.GOX.0000502973.63415.6f. PMCID: PMC5147141.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-03. Medicare National Coverage Determinations (NCD) Manual.

Centers for Medicare & Medicaid Services (CMS). Medicare Coverage Database.

Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Morbid Obesity (100.1). Effective Date 2013 Sep24.

Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Intensive Behavioral Therapy for Obesity (210.12). Effective Date 2011 Nov 29.

Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Medical Nutrition Therapy (180.1). Effective Date 2002 Oct 1.

Chung CW, Kling RE, Sivak WN, Rubin JP, Gusenoff JA. Risk factors for pannus formation in the post-bariatric surgery population. Plast Reconstr Surg. 2014 May;133(5):623e-627e. doi: 10.1097/PRS.0000000000000101. PMID: 24776564.

Colabianchi V, de Bernardinis G, Giovannini M, Langella M. Panniculectomy Combined with Bariatric Surgery by Laparotomy: An Analysis of 325 Cases. Surg Res Pract. 2015;2015:193670. doi: 10.1155/2015/193670. Epub 2015 Nov 15. PMID: 26682282.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Manuals.

Commonwealth of Massachusetts. MassHealth Transmittal Letters.

Danby FW, Hazen PG, Boer J. New and traditional surgical approaches to hidradenitis suppurativa. J Am Acad Dermatol. 2015 Nov;73(5 Suppl 1):S62-5. doi: 10.1016/j.jaad.2015.07.043. PMID: 26470619.

Fischer JP, Tuggle CT, Wes AM, Kovach SJ. Concurrent panniculectomy with open ventral hernia repair has added risk versus ventral hernia repair: an analysis of the ACS-NSQIP database. J Plast Recontr Aesthet Surg. 2014 May;67(5):693-701. doi: 10.1016/j.bjps.2014.01.021. Epub 2014 Jan 28. PMID: 24525270.

García PK, Vargas DC, Contreras K, González C, Rodríguez MP, Bermúdez LE. Abdominoplasty in Hemodialysis Patients Before Transplant. Exp Clin Transplant. 2020 Aug;18(4):512-14. doi: 10.6002/ect.2019.0006. Epub 2019 Oct 1. PMID: 31580239.

Grieco M, Grignaffini E, Simonacci F, Raposio E. Analysis of Complications in Postbariatric Abdominoplasty: Our Experience. Plast Surg Int. 2015;2015:209173. doi: 10.1155/2015/209173. PMID: 26236501.

Gupta V, Winocour J, Rodriguez-Feo C, Bamba R, Shack RB, Grotting JC, Higdon KK. Safety of Aesthetic Surgery in the Overweight Patient: Analysis of 127,961 Patients. Aesthet Surg J. 2016 Jun;36(6):718-29. doi: 10.1093/asj/sjv268. Epub 2016 Feb 9. PMID: 26895958.

Hillenbrand A, Henne-Bruns D, Wolf AM. Panniculus, giant hernias and surgical problems in patients with morbid obesity. GMS Interdiscip Plast Reconstr Surg DGPW. 2012Jan9;1:Doc05. doi: 10.3205/iprs000005. PMID: 26504689.

Janis JE, Jefferson RC, Kraft CT. Panniculectomy: Practical Pearls and Pitfalls. Plast Reconstr Surg Glob Open. 2020 Aug;8(8):e3029. doi: 10.1097/GOX.0000000000003029. PMID: 32983784.

MassHealth Guidelines for Medical Necessity Determination for Excision of Excessive Skin and Subcutaneous Tissue. 2017 Dec 22. Executive Office of the Health and Human Services.

New Hampshire Department of Health and Human Services. Billing Manuals.

New Hampshire Department of Health and Human Services. Provider Notices.

Pestana IA, Campbell D, Fearmonti RM, Bond JE, Erdmann D. "Supersize" panniculectomy: indications, technique, and results. Ann Plast Surg. 2014 Oct;73(4):416-21. doi: 10.1097/SAP.0b013e31827f5496. PMID: 23722576.

Rasmussen RW, Patibandla JR, Hopkins MP. Evaluation of indicated non-cosmetic panniculectomy at time of gynecologic surgery. Int J Gynaecol Obstet. 2017 Aug;138(2):207-211. doi: 10.1002/ijgo.12207. Epub 2017 May 31. PMID: 28494111.

Salunke AA. Massive panniculectomy: a novel method of treatment of postlaparotomy wound dehiscence in morbid obesity. Can J Surg. 2014 Apr;57(2):E53–54. doi: 10.1503/cjs.029213. PMID: 24666460.

Smith LF, Smith LF Jr. Safely combining abdominoplasty with aggressive abdominal liposuction based on perforator vessels: technique and a review of 300 consecutive cases. Plast Reconstr Surg. 2015 May;135(5):1357–1366. Published online 2015 Apr 19. doi: 10.1097/PRS.0000000000001200. PMID: 25919250.

Sugio Y, Tomita K, Hosokawa K. Reconstruction after Excision of Hidradenitis Suppurativa: Are Skin Grafts Better than Flaps? Plast Reconstr Surg Glob Open. 2016 Nov;4(11):e1128. Published online 2016 Nov 10. doi: 10.1097/GOX.0000000000001128. PMID: 27975030.

Troppmann C, Santhanakrishnan C, Kuo JH, Bailey CM, Perez RV, Wong MS. Impact of panniculectomy on transplant candidacy of obese patients with chronic kidney disease declined for kidney transplantation because of a high-risk abdominal panniculus: A pilot study. Surgery. 2016 Jun;159(6):1612-1622. doi: 10.1016/j.surg.2015.12.001. Epub 2016 Jan 16. PMID: 26785910.

Vilallonga R. Comment on "Panniculectomy Combined with Bariatric Surgery by Laparotomy: An Analysis of 325 Cases." Surg Res Pract. 2016;2016:9709283. Published online 2016 Jan 4. doi: 10.1155/2016/9709283. PMID: 26933675.

Wallace SA, Mericli AF, Taylor PT, Drake DB. Panniculectomy and abdominoplasty in patients undergoing gynecologic surgery: a single center case series of 15 combined procedures. Ann Plast Surg. 2013 Jul;71(1):88-92. doi: 10.1097/SAP.0b013e31824143b7. PMID: 23364668.

Warren JA, Epps M, Debrux C, Fowler JL 3rd, Ewing JA, Cobb WS 4th, Carbonell AM. Surgical Site Occurrences of Simultaneous Panniculectomy and Incisional Hernia Repair. Am Surg. 2015 Aug;81(8):764-9. PMID: 26215237.

Winocour J, Gupta V, Ramirez JR, Shack RB, Grotting JC, Higdon KK. Abdominoplasty: Risk Factors, Complication Rates, and Safety of Combined Procedures. Plast Reconstr Surg. 2015 Nov;136(5):597e-606e. doi: 10.1097/PRS.0000000000001700. PMID: 26505716.

Zyła M, Nowinska-Serwach A, Nowak M, Stetkiewicz T, Wilamowska A, Szpakowski A, Litwinska E, Baum M, Kajdos M, Rycel M, Wilczynski M, Wilczynski JR. The use of panniculectomy in morbidly obese patients undergoing gynecological surgery. Neuro Endocrinol Lett. 2014;35(2):98-103. PMID: 24878982.

Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by

Regulatory Approval: N/A Internal Approval: 01/19/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 02/23/11: Quality Improvement Committee (QIC)	05/01/11 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

(Policy formerly titled Redundant Skin Surgery Procedure until 04/30/13.)

Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
01/01/12	Added that the surgical removal of redundant skin or body contouring for cosmetic purposes only including brachioplasty, thighplasty and other body areas are considered cosmetic, updated references and coding.	Version 2	01/18/12: MPCTAC 02/08/12: QIC
08/01/12	Off cycle review for WellSense Health Plan. Revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory statement, updated code list, revised Limitations statement	Version 3	08/17/12: MPCTAC 09/06/12: QIC
01/01/13	Review for effective date 05/01/13. Revised title, added Definitions section and moved definitions from Description of Item or Service to Definitions section, reformatted clinical criteria in Medical Policy Statement section, revised Limitations section, revised introductory paragraph and table headings in Applicable Coding section.	05/01/13 Version 4	01/16/13: MPCTAC 02/21/13: QIC

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Policy Revisions History			
	Referenced the following policies: *Medically Necessary* and *Cosmetic, Reconstructive, and Restorative Services*. Changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy."		
08/14/13 and 08/15/13	Off cycle review for WellSense Health Plan and merged policy format. Incorporate policy revisions dated 01/01/13 (as specified above) for the WellSense Health Plan product; these policy revisions were approved by MPCTAC on 01/16/13 and QIC on 02/21/13 for applicable Plan products.	Version 5	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
01/01/14	Review for effective date 05/01/14. Updated References and Clinical Background Information sections. Revised policy title to specify redundant skin surgery related to panniculectomy. Revised criteria in Medical Policy Statement section. Revised Limitations section without changing criteria.	05/01/14 Version 6	01/15/14: MPCTAC 02/18/14: QIC
01/01/15	Review for effective date 03/01/15. Updated Definitions and References sections.	03/01/15 Version 7	01/21/15: MPCTAC 02/11/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and corresponding notes. Updated language in the Applicable Coding section.	01/01/16 Version 8	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
11/25/15	Review for effective date 03/01/16. Revised criteria in the Medical Policy Statement and Limitations sections. Revised Definitions section.	03/01/16 Version 9	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
11/01/16	Review for effective date 01/01/17. Revised Description of Item or Service, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	01/01/17 Version 10	11/16/16: MPCTAC 12/14/16: QIC
11/01/17	Review for effective date 02/01/18. Administrative changes made to the	02/01/18 Version 11	11/15/17: MPCTAC

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Policy Revisions History			
	Description of Item or Service, Clinical Background Information, and References sections. Criteria changes made in the Medical Policy Statement and Limitations sections.		
11/01/18	Review for effective date 02/01/19. Administrative changes made to the Limitations, Clinical Background Information, References, and Other Applicable Policies sections. Revised criteria in the Medical Policy Statement section.	12/01/18 Version 12	11/21/18: MPCTAC
11/01/19	Review for effective date 12/01/19. Administrative changes made to the Medical Policy Statement, Limitations, References, and Reference to Applicable Laws and Regulations sections.	12/01/19 Version 13	11/20/19: MPCTAC
12/01/20	Review for effective date 03/01/21. Criteria revised in the Medical Policy Statement and Limitations sections. Administrative changes made to the Description of Item or Service and References sections.	03/01/21 Version 14	12/16/20: MPCTAC
11/01/21	Review for effective date 01/01/22. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary and References sections.	01/01/22 Version 15	11/17/21: MPCTAC
11/01/21	Review for effective date 02/01/22. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections.	02/01/22 Version 16	11/17/21: MPCTAC

Next Review Date

11/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.