Medical Policy

Panniculectomy and Related Redundant Skin Surgery

Policy Number: OCA 3.722
Version Number: 9
Version Effective Date: 03/01/16

Product Applicability

<table>
<thead>
<tr>
<th>Product</th>
<th>All Plan* Products</th>
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<tbody>
<tr>
<td>Well Sense Health Plan</td>
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<tr>
<td>☑ New Hampshire Medicaid</td>
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<td>☑ NH Health Protection Program</td>
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<td>Boston Medical Center HealthNet Plan</td>
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<td>☑ MassHealth</td>
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<td>☑ Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
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<tr>
<td>☑ Senior Care Options ◊</td>
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Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers panniculectomy as a reconstructive procedure to be medically necessary when Plan medical criteria are met. Prior authorization is required. It will be determined during the Plan’s prior authorization process if the service is considered medically necessary for the requested indication. See the Plan’s policy, Medically Necessary (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment.
Description of Item or Service

**Panniculectomy**: The surgical removal of fatty tissue and excess skin (panniculus) from the lower to middle portions of the abdomen. The condition may accompany significant overstretching of the lax anterior abdominal wall and often occurs in morbidly obese individuals or following substantial weight loss. The severity of abdominal deformity is graded according to guidelines from the American Society of Plastic Surgeons, as specified below:

- **Grade 1**: Panniculus covers hairline and mons pubis but not the genitals
- **Grade 2**: Panniculus covers genitals and upper thigh crease
- **Grade 3**: Panniculus covers upper thigh
- **Grade 4**: Panniculus covers mid-thigh
- **Grade 5**: Panniculus covers knees and below

Medical Policy Statement

Frontal and lateral preoperative 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. Panniculectomy as a reconstructive procedure after weight loss or bariatric surgery is considered medically necessary when the following criteria are met and documented in the member’s medical record, as specified below in items 1 through 7:

1. The member’s panniculus is Grade 2 or greater (i.e., hangs below the level of the pubis); AND

2. No more than an additional 20 pounds weight loss is anticipated; AND

3. The member has maintained a stable weight within ONE (1) of following applicable time frames, as specified below in item a or item b:
   a. 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 and exercise, or medical intervention (without bariatric surgery); OR
   b. If the member has had bariatric surgery, BOTH of the following criteria must be met, as specified below in items (1) and (2):
      (1) The member is at least 18 months post operative since the bariatric surgery; AND
(2) The member has maintained a stable weight for at least the most recent 12 months post surgery when the weight loss is the result of bariatric surgery; AND

3. At least ONE (1) of the following conditions is documented in the member’s medical record, as specified below in item a or item b:

a. Significant difficulty ambulating which is directly related to the panniculus and is interfering with activities of daily living; OR

b. The pannus has resulted in the following, as specified below in criteria in BOTH item (1) and item (2):

   (1) At least 2 episodes in a 12-month period of ONE (1) or more of the following conditions specified below in items (a) through (d):

   (a) Cellulitis; OR

   (b) Infection; OR

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

   (d) Non-healing skin ulceration, skin maceration, or skin necrosis; AND

   (2) Documentation of failed treatment for each of the two (2) episodes in the specified 12-month period that included at least ONE (1) of the following treatments for each episode, as specified below in items (a) through (c)

   (a) Conventional wound healing interventions (such as debridement) for at least eight (8) weeks under the direct supervision of a treating provider with documentation of no measurable signs of improvement in wound healing; OR

   (b) Systematic antibiotics, systematic antifungals, or systemic corticosteroids for at least two (2) weeks; OR

   (c) Local or topical antibiotics, antifungals, corticosteroids for at least four (4) weeks under the direct supervision of a treating provider.

4. The member practices good hygiene techniques; AND

5. The patient is a good candidate for surgery; AND
6. The surgery is expected to restore or improve the documented functional deficit; AND

7. The member is 18 years of age or older on the date of service

**Limitations**

See the Plan’s policy, *Cosmetic, Reconstructive, and Restorative Services* (policy number OCA 3.69), for the product-specific definitions of cosmetic services/cosmetic surgery, reconstructive and restorative services, and physical functional impairment. Plan Medical Director review is required to determine if a service is reconstructive and restorative rather than cosmetic (e.g., abdominoplasty to close an open primary or secondary wound rather than for cosmetic reasons). The pannus or excess/redundant skin’s impact on the individual’s emotional well-being or mental health is not considered in determining if a physical functional impairment exists.

1. The following procedures are generally considered cosmetic because there is insufficient evidence in the peer reviewed medical literature to support the medically necessary use of ANY of these procedures, as specified below in items a through f.

   a. Abdominal liposuction or suction assisted lipectomy of the abdomen;

   b. Abdominoplasty;

   c. Mini abdominoplasty;

   d. Repair of diastasis recti or abdominal laxity;

   e. Panniculectomy as an adjunct to other procedures; AND/OR

   f. Panniculectomy for the treatment of back pain and/or neck pain, to reduce the risk of hernia formation or hernia recurrence, or for an indication not specified in this Plan policy and/or when Plan criteria are not met.

2. The surgical removal of redundant skin or body contouring, including brachioplasty, thighplasty and other body areas, may be considered cosmetic and will require Plan review according to the guidelines specified in the *Cosmetic, Reconstructive, and Restorative Services* policy referenced above.

3. The Plan requires Medical Director review to determine the medical necessity of a request for panniculectomy for a member less than 18 years of age on the date of service.

4. Liposuction is often an integral part the surgical removal of excessive skin; liposuction is not separately reimbursed when the member is authorized for panniculectomy.
Definitions

**Abdominoplasty**: A cosmetic procedure that firms and flattens the abdomen by the placement of transverse suprapubic/lower abdominal and periumbilical incisions. The abdominal skin is then tightened by excising the caudal portion of abdominal skin and creating a new umbilical opening higher up on the skin that has now been stretched downward. In most cases, tightening of the abdominal musculature is also performed by suture plication of the rectus sheaths.

**Diastasis Recti**: A widening of the linea alba with separation of the rectus muscles. The linea alba is a fibrous band running vertically the entire length of the center of the anterior abdominal wall, receiving the attachments of the oblique and transverse abdominal muscles.

**Lipectomy**: A surgical technique that is used to cut and remove unwanted fat deposits from specific areas of the body. It is not a substitute for weight reduction, but is a method of removing localized fat that does not respond to dieting and exercise. A lipectomy may be done for cosmetic reasons or to treat functional impairment.

**Mini Abdominoplasty**: A partial abdominoplasty involving the incision of the lower abdomen only. The procedure is generally performed solely for cosmetic purposes in order to improve the appearance of the abdominal area.

**Suction Assisted Lipectomy of the Abdomen**: Also known as abdominal liposuction, this is a procedure in which excess fat deposits are removed from the trunk using a liposuction cannula with the goal of reshaping the body, thereby improving appearance. This procedure may be performed alone or as one component of an overall abdominoplasty or panniculectomy procedure.

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 States 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). Because 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 Medical Policy Statement section and Limitation section of this Plan policy, 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. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member.

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<tr>
<th>CPT Code</th>
<th>Description: Code Covered When Medically Necessary</th>
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<tbody>
<tr>
<td>15830</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy</td>
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<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description: Codes Considered Cosmetic and Not Medically Necessary</th>
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<tr>
<td>15832</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</td>
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<td>15833</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg</td>
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<tr>
<td>15834</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip</td>
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<tr>
<td>15835</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttoc</td>
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<td>15836</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm</td>
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<tr>
<td>15837</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand</td>
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<td>15838</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad</td>
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<td>15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</td>
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<td>15847</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)</td>
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<td>15876</td>
<td>Suction assisted lipectomy; head and neck</td>
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<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
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<td>15878</td>
<td>Suction assisted lipectomy; upper extremity</td>
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<tr>
<td>15879</td>
<td>Suction assisted lipectomy; lower extremity</td>
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**Clinical Background Information**

Panniculectomy is a surgical procedure that removes a large flap or apron of redundant skin and fat (panniculus) between the navel and the pubis that may hang down from the abdomen to cover the pubis, groin, and upper thighs. Abdominoplasty, referred to as a “tummy tuck,” is a procedure involving the removal of excess abdominal skin and fat, with or without tightening lax anterior abdominal wall muscles, and with or without repositioning or reconstruction of the navel. This reshaping of the abdominal wall area is often performed solely to improve the appearance of a protuberant abdomen by creating a flatter, firmer abdomen. Abdominoplasty and panniculectomy are often performed together to achieve the best cosmetic result. Most abdominoplasty and panniculectomy procedures typically last about 1-4 hours and may require overnight monitoring; however many patients are able to have these procedures in the outpatient setting. Panniculectomy is associated with a high postoperative complication rate (approximately 40%), although most
complications are mild and treatable. The most common complications include disturbances in wound healing and wound infection, hematoma, and seroma. Major complications that require hospitalization or surgical reintervention occur in 10% to 15% of patients.

According to the American Society of Plastic Surgeons (ASPS) Practice Parameter for Abdominoplasty and Panniculectomy, the procedures are most commonly performed for cosmetic indications. However, there are reconstructive indications such as abdominal wall defects, irregularities or pain caused by previous pelvic or lower abdominal surgery, umbilical hernias, intertriginous skin conditions and scarring. The ASPS-recommended coverage criteria state that an abdominoplasty or panniculectomy should be considered a reconstructive procedure when performed to correct or relieve structural defects of the abdominal wall. When an abdominoplasty or panniculectomy is performed solely to enhance a patient’s appearance in the absence of any signs or symptoms of functional abnormalities, the procedure should be considered cosmetic. The ASPS Practice Parameter for Surgical Treatment of Skin Redundancy Following Massive Weight Loss states that body contouring surgery is ideally performed after the patient maintains a stable weight for two (2) to six (6) months. For post bariatric surgery patients, this often occurs 12 to 18 months after surgery or at a body mass index (BMI) weight range of 25 kg/m² to 30 kg/ m² weight range.

References


<table>
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<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tr>
<td>Regulatory Approval: N/A</td>
<td>05/01/11 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC and QIC</td>
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<td>Internal Approval: 01/19/11: MPCTAC 02/23/11: QIC</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Heath Plan New Hampshire Medicaid Product(s): 01/01/13

(Policy formerly titled Redundant Skin Surgery Procedure until 04/30/13.)
<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
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<tr>
<td>01/01/12</td>
<td>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.</td>
<td>Version 2</td>
<td>01/18/12: MPCTAC 02/08/12: QIC</td>
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<tr>
<td>08/01/12</td>
<td>Off cycle review for Well Sense Health Plan. Revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory statement, updated code list, revised Limitations statement</td>
<td>Version 3</td>
<td>08/17/12: MPCTAC 09/06/12: QIC</td>
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<td>01/01/13</td>
<td>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. Referenced the following policies: Medically Necessary and Cosmetic, Reconstructive, and Restorative Services. Changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”</td>
<td>05/01/13 Version 4</td>
<td>01/16/13: MPCTAC 02/21/13: QIC</td>
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<td>08/14/13 and 08/15/13</td>
<td>Off cycle review for Well Sense Health Plan and merged policy format. Incorporate policy revisions dated 01/01/13 (as specified above) for the Well Sense Health Plan product; these policy revisions were approved by MPCTAC on 01/16/13 and QIC on 02/21/13 for applicable Plan products.</td>
<td>Version 5</td>
<td>08/14/13: MPCTAC (electronic vote) 08/15/13: QIC</td>
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<tr>
<td>01/01/14</td>
<td>Review for effective date 05/01/14. Updated References and Clinical Background Information sections. Revised policy title to specify redundant skin surgery related to</td>
<td>05/01/14 Version 6</td>
<td>01/15/14: MPCTAC 02/18/14: QIC</td>
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Panniculectomy and Related Redundant Skin Surgery

*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 Well Sense Health Plan.
Policy Revisions History

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<th>Description</th>
<th>Revised Date</th>
<th>Authorizing Entity</th>
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<tr>
<td>01/01/15</td>
<td>Review for effective date 03/01/15. Updated Definitions and References sections.</td>
<td>03/01/15</td>
<td>MPCTAC 02/11/15: QIC</td>
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<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and corresponding notes. Updated language in the Applicable Coding section.</td>
<td>01/01/16</td>
<td>MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC</td>
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Last Review Date

11/25/15

Next Review Date

11/01/16

Authorizing Entity

QIC

Other Applicable Policies

Medical Policy - *Bariatric Surgery*, policy number OCA 3.49
Medical Policy - *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69
Medical Policy - *Medically Necessary*, policy number OCA 3.14:

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.

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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.

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