1. POLICY DESCRIPTION:
Abdominoplasty/Panniculectomy

2. RESPONSIBLE PARTIES:
Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:
Abdominoplasty: A surgical procedure that tightens the lax anterior abdominal wall and removes excess abdominal skin and other tissue.

Panniculectomy: The surgical excision of the panniculus (abdominal fat apron). These procedures are deemed cosmetic when performed solely to refine or reshape structures or surfaces that are not functionally impaired. When performed to correct or relieve structural abdominal wall defects that result in significant functional impairment, they are deemed reconstructive.

4. POLICY:
Related Medical Guideline
Cosmetic Surgery Procedures
In the case that more than one procedure is to be performed, coverage will only be applicable to the reconstructive procedure; the cost of the cosmetic procedure (i.e., abdominoplasty in association with panniculectomy) will be the responsibility of the member (as per group contract, individual contract or policy). Additionally, photographic evidence must accompany written documentation substantiating medical necessity.

Members are eligible for coverage of abdominoplasty/panniculectomy when the following criteria are documented as met:

- Stability of weight for a period of 12 months post weight loss and/or bariatric surgery.

AND ≥ 1 OF THE FOLLOWING

- Presence of necrotic skin or skin ulcerations (photographic documentation required).
- Presence of recurrent skin infections that have been refractory to systemic antibiotic or antifungal treatment (defined as > 2 occurrences within a 12-month period).
- Presence of intertriginous skin rashes that have been refractory to a 3-month trial of dermatologist-supervised treatments.

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1 Functional impairment refers to an extensive redundancy of skin and fat folds (e.g., a panniculus below the pubis). The development is often secondary to massive weight loss. An abdominal panniculus of this extent is causal to functional impairment.
5. LIMITATIONS/EXCLUSIONS:

NOTE: PANNICULECTOMY IS CONSIDERED MEDICALLY NECESSARY AS AN ADJUNCT TO A MEDICALLY NECESSARY SURGERY WHEN NEEDED FOR EXPOSURE IN EXTRAORDINARY CIRCUMSTANCES (E.G., AS PART OF PELVIC SURGERY IN WHICH A LARGE PANNUS CAN OBSTRUCT VISUALIZATION OR WHEN EXCISION OF A HEAVY PANNUS IS NEEDED TO PREVENT POSTOPERATIVE ABDOMINAL WOUND DEHISCENCE).

The following procedures, when performed to assist with back pain, are not considered medically necessary:
- Abdominoplasty
- Diastasis recti repair
- Panniculectomy

6. APPLICABLE PROCEDURE CODES:

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<tr>
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<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy</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) (List separately in addition to code for primary procedure)</td>
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7. APPLICABLE DIAGNOSIS CODES:
Policy and Procedure

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<td>L30.4</td>
<td>Erythema intertrigo</td>
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<td>L98.491</td>
<td>Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin</td>
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<td>L98.492</td>
<td>Non-pressure chronic ulcer of skin of other sites with fat layer exposed</td>
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<tr>
<td>L98.7</td>
<td>Excessive and redundant skin and subcutaneous tissue (eff. 10/01/2016)</td>
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<td>L98.8</td>
<td>Other specified disorders of the skin and subcutaneous tissue</td>
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<td>M35.6</td>
<td>Relapsing panniculitis [Weber-Christian]</td>
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<td>M79.3</td>
<td>Panniculitis, unspecified</td>
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</table>

8. REFERENCES:


Specialty-matched clinical peer review.

The Safety of Pelvic Surgery in the Morbidly Obese With and Without Combined Panniculectomy: A Comparison of Results. Hardy, James E. MD; Salgado, Christopher J. MD;
Title: Abdominoplasty/Panniculectomy  
Division: Medical Management  
Department: Utilization Management  

**Approval Date:** 7/20/17  
**LOB:** Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP  
**Effective Date:** 7/20/17  
**Review Date:** 9/28/18  
**Policy Number:** UM-MP200  
**Retired Date:** Page 4 of 5  

Matthews, Martha S. MD; Chamoun, George MD; Fahey, A Leilani MD Annals of Plastic Surgery: January 2008 - Volume 60 - Issue 1 - pp 10-13  

**REVISION LOG:**  
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Approved:  
Sosler Bruce, MD  
Clinical Medical Director  

Approved:  
Talya Schwartz, MD  
Chief Medical Officer
## Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member’s benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication. MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.