MEDICAL POLICY	Liposuction for Lipedema (Medicare Only)
Effective Date: 9/1/2022	Medical Policy Number: 351
 9/1/2022	Medical Policy Committee Approved Date: 8/2022
Medical Officer Date	

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

DOCUMENTATION REQUIREMENTS:

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
  - History
  - Physical examination
  - Treatment plan

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Liposuction *(Suction Assisted Lipectomy) (15877-15879)*	Local Coverage Determination (LCD) for *Plastic Surgery* (L37020) **NOTE:** This LCD states, "…when the procedure is utilized to remove a lipoma, it is considered reconstructive surgery. The clinical record must clearly demonstrate medical necessity for the lipoma removal as most such tumors are benign and do not require removal. All

	other uses are currently considered cosmetic in nature and non-covered." Therefore, suction assisted lipectomy is considered cosmetic for any condition other than lipomas.
Excision (with or without Lipectomy) (15832-15836)	Company medical policy for Liposuction for Lipedema (All Lines of Business Except Medicare) I. This service may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. This service is considered **not medically necessary** for Medicare when the Company medical policy criteria are **not** met. *See Policy Guidelines below.*

POLICY GUIDELINES

Lipectomy and Liposuction

Lipectomy is the surgical removal of adipose or fat tissue. A lipectomy can be performed in order to excise a lipoma (a fatty tumor), but it can also be performed to remove excess fatty tissue to reshape the contours of the face, neck, trunk, and extremities as a component of cosmetic surgery.

Liposuction (suction-assisted lipectomy) is the aspiration of subcutaneous fat via a suction method. A suction cannula is inserted through a small incision into the fatty areas and a vacuum is applied, allowing the fat to be drawn out of the body into collection containers. Liposuction is also frequently a component of cosmetic surgery.

Medicare and Medical Necessity

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*.

BILLING GUIDELINES

General

See associated local coverage articles (LCAs) for related billing and coding guidance:

- LCA: Billing and Coding: Plastic Surgery (A57222)

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
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
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

MEDICAL POLICY CROSS REFERENCES

- Bariatric Surgery (Medicare Only), MP37
- Cosmetic and Reconstructive Procedures (Medicare Only), MP232