Surgical Treatment for Skin Redundancy

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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 Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. 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. 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.

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”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Panniculectomy Following Significant Weight Loss

I. Panniculectomy following significant weight loss may be considered **medically necessary** when **all** of the following criteria are met (A.-E.):

   A. Pannus hangs at or below the level of the symphysis pubis, as demonstrated on pre-operative photographs; **and**
   B. Pannus causes a chronic and persistent skin condition documented by photographs (e.g., intertrigo, intertriginous dermatitis, panniculitis, cellulitis, skin ulcers or tissue necrosis) that is refractory to at least 6 months of medical treatment (e.g. oral and/or topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics if not contraindicated); **and**
   C. Pannus interferes with activities of daily living; **and**
   D. Clinical documents indicate the patient's weight has remained stable for at least 6 months; **and**
   E. If patient's significant weight loss is the result of bariatric surgery, the procedure is performed at 18 months after the bariatric surgery and clinical documents indicate the patient's weight has remained stable in the most recent 6 months.

II. Panniculectomy following significant weight loss is considered **not medically necessary** when criterion I. above is not met.

Panniculectomy **Not** Following Significant Weight Loss

III. Panniculectomy not following significant weight loss may be considered **medically necessary** when **all** of the following criteria are met (A.-C.):

A. Pannus hangs at or below the level of the symphysis pubis, as demonstrated on pre-operative photographs; **and**
B. Pannus causes a chronic and persistent skin condition documented by photographs (e.g., intertrigo, intertriginous dermatitis, panniculitis, cellulitis, skin ulcers or tissue necrosis) that is refractory to at least 6 months of medical treatment (e.g., oral and/or topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics if not contraindicated); **and**
C. Pannus interferes with activities of daily living.

III. Panniculectomy not following significant wight loss is considered **not medically necessary** when criterion III. is not met.

Surgical Treatment of Other Anatomical Areas

IV. Surgical treatment of redundant or excessive skin for other anatomical areas (e.g., upper and lower extremities, buttocks) may be considered **medical necessary** when **all** of the following criteria (A.- G.) are met:

A. There is presence of a functional deficit due to a severe physical deformity or disfigurement resulting from the abundant or excessive skin; **and**
B. The surgery is expected to restore or improve the functional deficit; **and**
C. The redundant or excessive skin is demonstrated on preoperative photographs **or** detailed description on physical exam including approximate measurements; **and**
D. The redundant or excessive skin is interfering with activities of daily living; **and**
E. For areas other than the face, photographic evidence or detailed exam indicates that redundant or excessive skin is causing chronic and persistent intertrigo, intertriginous dermatitis, cellulitis, skin ulcerations or tissue necrosis, which is refractory to at least 6 months of medical management, including all applicable treatments (e.g., oral and/or topical antifungals; topical and/or systemic corticosteroids, and/or local or systemic antibiotics if not contraindicated); **and**
F. If the procedure is being performed following significant weight loss, clinical documents indicate the patient's weight has remained stable for at least 6 months; **and**
G. If the significant weight loss is the result of bariatric surgery, the procedure is performed 18 months after the bariatric surgery and clinical documents indicate that patient's weight has remained stable in the most recent 6 months.

V. Surgical treatment of redundant or excessive skin for other anatomical areas (e.g., upper and lower extremities, buttocks) is considered **not medically necessary** when criterion IV. is not met.

Non-Coverage Criteria

VI. Abdominoplasty (i.e. "tummy tuck") is considered **cosmetic** for the treatment of any indication.

VII. Surgical procedures to remove excessive or redundant skin are considered including, but not limited to, any of the following:

- Surgery performed solely to enhance a patient's appearance in the absence of any signs or symptoms of functional abnormalities.
- Treatment of neck or back pain.
- For the sole purpose of repairing abdominal wall laxity or diastasis recti.
- For the sole purpose of improving appearance, including garment fit.
- When performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery)
- Suction-assisted lipectomy to treat any anatomical area.

POLICY CROSS REFERENCES

- Cosmetic and Reconstructive Procedures, MP98

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

BACKGROUND

There are a wide range of defects of varying severity that may benefit from the removal of excess skin and fat. Examples of reconstructive indication may include:

- Abdominal wall defects, irregularities or pain caused by previous pelvic or lower abdominal surgery
- Umbilical hernias
- Intertriginous skin conditions
- Scarring

According to the American Society of Plastic Surgeons:[1-4]

> "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 placation of the rectus muscle diastasis and neoumbilicoplasty.
>
> Mini or modified abdominoplasties are also typically performed for cosmetic purposes 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 placation, neoumbilicoplasty or flap elevation. A cosmetic abdominoplasty is sometimes performed at the time of a functional panniculectomy.

"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.
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 gynecomastia by suction assisted lipectomy/ultrasound assisted lipectomy or excision.

Circumferential lipectomy combines an abdominoplasty with a "back lift", both procedures being performed together sequentially and including suction assisted lipectomy, where necessary.

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. The procedure lifts tissues all the way from the knee level and reduces, but does not eliminate, the need for subsequent thigh lifts. A lower body lift tends to stress thigh lifting along with truncal improvement."

Cosmetic versus Reconstructive Surgery

Per the American Medical Association (AMA) policy H-475.992:[5]

Reconstructive Surgery is defined as surgery performed on *abnormal* structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Cosmetic Surgery is defined as surgery performed to reshape *normal* structures of the body to improve the patient's appearance and self-esteem.

Only in rare circumstances will buttock, thigh, or arm lifts be needed to treat functional abnormalities. These procedures are typically performed to improve appearance and are typically cosmetic in nature.

Pannus Grade

According to the American Society of Plastic Surgeons (ASPS), "Excess skin and fat affect the entire trunk region; however, the area that is usually emphasized is the anterior abdomen. The severity of abdominal deformities is graded as follows:[4]

- 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”

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

CLINICAL EVIDENCE AND LITERATURE REVIEW

EVIDENCE REVIEW
No evidence review was conducted regarding the removal of excess skin or fat for the treatment of various conditions. Criteria above are based largely on clinical practice guidelines, discussed below..

CLINICAL PRACTICE GUIDELINES

American Society of Plastic Surgeons (ASPS)

- In 2019, the ASPS published insurance coverage criteria for third-party payers for panniculectomy.[2] According to the guideline:

> “Panniculectomy has been shown to improve functional quality of life. Activities of daily living, treatment of buried penis, access to renal transplant lists, and facilitation of concomitant surgical procedures have all been documented. Though complication rates are high, safety appears to be improving over time, and plastic surgery trained surgeons appear to have lower complication rates than non-plastic surgery trained surgeons.
>
> When an abdominoplasty or panniculectomy are 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 in nature and not a compensable procedure unless specified in the patient's policy.
>
> Panniculectomy should be considered a reconstructive procedure when performed to correct or relieve structural defects of the abdominal wall, improve skin health within the fold beneath the pannus, and/or help improve chronic low back pain due to functional incompetence of the anterior abdominal wall.
>
> In rare circumstances, plastic surgeons may perform a hernia repair in conjunction with an abdominoplasty or panniculectomy. A true hernia repair involves opening fascia and/or dissection of a hernia sac with return of intraperitoneal contents back to the peritoneal cavity. A true hernia repair should not be confused with diastasis recti repair, which is often part of a standard abdominoplasty.”[2]

- In 2018, the ASPS for published insurance coverage criteria for third-party payers for abdominoplasty.[3] According to the guideline:

  > "When an abdominoplasty 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 in nature and not a compensable procedure unless specified in the patient's policy.
  >
  > In the case where a panniculectomy is combined with plication of the rectus abdominis muscle and/or translocation of the umbilicus, this may be completed as a single stage procedure but the plication of the rectus abdominis muscle and/or translocation of umbiicus should be considered purely cosmetic…"[3]

- In 2017, the ASPS published insurance coverage criteria for third-party payers for surgical treatment of skin redundancy for obese and massive weight loss patients.[1] According to the guideline:

  > "Circumstances will buttock, thigh or arm lifts be needed to treat functional abnormalities. Typically, these procedures are performed to improve appearance and are therefore cosmetic in nature.
  >
  > Patients considered for panniculectomy may be required to/ should document the type and duration of symptoms/ treatment for panniculitis. Documented recalcitrant panniculitis may be considered as indication for panniculectomy. Photographs should confirm the patients' medical condition.
  >
  > Patients considered for panniculectomy may be required to/ should document specialist (back) evaluation, radiological evaluation and duration of symptoms/ treatment for chronic back pain felt related to their panniculus. Direct correlation is recommended before panniculectomy is considered. Photographs should confirm the patients' medical condition. Improvement in a patient's activities of daily living should not be considered as an indication for panniculectomy."[1]

- In 2019, the ASPS published a practice parameter for surgical treatment of skin redundancy for obese and massive weight loss patients.[4] Specific indications for trunk, breast, arms, and thighs are delineated in the practice parameter.

American Association of Clinical Endocrinologists, Obesity Society, American Society for Metabolic & Bariatric Surgery

In 2013, the American Association of Clinical Endocrinologists, Obesity Society, and American Society for Metabolic & Bariatric Surgery updated a co-sponsored guideline regarding perioperative support of bariatric surgery patients.[6] The group indicated the following regarding body-contouring surgery:

> "Body-contouring surgery may be performed after bariatric surgery to manage excess tissue that impairs hygiene, causes discomfort, and is disfiguring (Grade C; BEL 3) .This surgery is best pursued after weight loss has stabilized (12 to 18 months after bariatric surgery) (Grade D).[6]

The recommendations above are based on weak evidence and consensus opinion.

BILLING GUIDELINES AND CODING

CODES*		
CPT	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/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 placation) (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

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. https://www.plasticsurgery.org/Documents/Health-Policy/Reimbursement/insurance-2017-skin-redundancy-for-obese-and-massive-weight-loss-patients.pdf. Published 2017. Accessed 1/24/2023.
2. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Panniculectomy. https://www.plasticsurgery.org/Documents/Health-Policy/Reimbursement/insurance-2019-panniculectomy.pdf. Published 2019. Accessed 1/24/2023.
3. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Abdomioplasty. https://www.plasticsurgery.org/Documents/Health-Policy/Reimbursement/insurance-2018-abdominoplasty.pdf. Published 2018. Accessed 1/24/2023.
4. American Society of Plastic Surgeons. ASPS Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. https://www.plasticsurgery.org/documents/Health-Policy/Guidelines/guideline-2017-skin-redundancy.pdf. Published 2019. Accessed 1/24/2023.
5. American Medical Association. Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992. https://policysearch.ama-assn.org/policyfinder/detail/cosmetic?uri=%2FAMADoc%2FHOD.xml-0-4326.xml. Accessed 1/24/2023.
6. Mechanick JI, Youdim A, Jones DB, et al. Clinical practice guidelines for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient--2013 update: cosponsored by American Association of Clinical Endocrinologists, the Obesity Society, and American Society for Metabolic & Bariatric Surgery. *Endocrine practice : official journal of the American College of Endocrinology and the American Association of Clinical Endocrinologists.* 2013;19(2):337-372.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
3/2023	Annual update, no changes