Sentara Health Plans

Medicaid

Panniculectomy

Table of Content
Purpose Description & Definitions Criteria Coding Document History References Special Notes Keywords

Effective Date	11/1991
Next Review Date	2/13/2024
Coverage Policy	Surgical 14
Version	6

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

Purpose:

This policy addresses the surgery, Panniculectomy.

Description & Definitions:

Abdominoplasty is a cosmetic surgical procedure to remove excess skin from the abdomen and tighten the rectus muscle.

Panniculectomy is reconstructive surgical procedure to remove excess skin and tissue from the lower abdomen that hangs over the pubis and causes skin irritation and/or infection. This procedure does not tighten the abdominal muscles.

Criteria:

Panniculectomy is considered medically necessary for **all of the following**:

- Panniculus hangs below the level of the pubis
- Panniculus causes **1 or more** of the following:
  - **Skin impairment, refractory** to conservative, medical therapy (local and/or oral) for at least three months with **1 or more** of the following:
    - Chronic intertrigo, rashes, cellulitis, infections, or non-healing ulcers
  - Functional impairment such as difficulty with walking and activities of daily living and the surgery will correct/improve the functional impairment
- Photos have been submitted that document **all of the** following:
  - The panniculus hangs below the level of the pubis
  - Evidence of chronic intertrigo, rashes, cellulitis, infections, or non-healing ulcers when the panniculus is lifted
- Prior to surgery, Individual's weight has been addressed, as indicated by **1 or more** of the following:

- Individual’s weight has been stable, without significant weight loss.
- Prior to surgery, Individual has had significant weight loss, and **1 or more** of the following:
  - Individual’s weight has been stable for at least 3 to 6 months
  - Individual’s bariatric surgery was at least 18 months ago, and weight has stabilized for at least 3 to 6 months

Procedures considered cosmetic are considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Abdominal lipectomy (when done independently and not part of an approved panniculectomy procedure)
- Abdominoplasty
- Liposuction
- Repair of diastasis recti

Coding:

Medically necessary with criteria:

Coding	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)

Considered Not Medically Necessary:

Coding	Description
15877	Suction assisted lipectomy; trunk

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2024: February
- 2022: February
- 2020: August
- 2019: November
- 2016: May
- 2015: July, August
- 2014: January
- 2012: September
- 2008: August
- 2007: August, September

Reviewed Dates:

- 2023: February
- 2021: December
- 2019: February
- 2018: March
- 2017: January
- 2014: August

- 2013: September
- 2011: September
- 2010: September
- 2009: August
- 2006: July
- 2004: November

Effective Date:

- November 1991

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2024). Retrieved Jan 2024, from MCG 27th Edition: https://careweb.careguidelines.com/ed27/index.html

(2024). Retrieved Jan 2024, from DMAS Provider Manual: https://vamedicaid.dmas.virginia.gov/pdf_chapter/practitioner#gsc.tab=0

(2024). Retrieved Jan 2024, from Hayes: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522panniculectomy%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%2522:%2

Local Coverage Determination (LCD) - Cosmetic and Reconstructive Surgery L33428. (2021, Jul 29). Retrieved Jan 2024, from CMS LCD: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33428&ver=53

Panniculectomy. (2023, Jul 18). Retrieved Jan 2024, from National Library of Medicine - StatPearls: https://www.ncbi.nlm.nih.gov/books/NBK499822/#:~:text=A%20panniculectomy%20is%20an%20operative,a%20large%20overhanging%20abdominal%20panniculus.

Panniculectomy. (2024). Retrieved Jan 2024, from American Society of Plastic Surgeons: https://www.plasticsurgery.org/reconstructive-procedures/panniculectomy/candidates#:~:text=You%20have%20realistic%20expectations,the%20hanging%20fold%20of%20skin

Special Notes: *

This medical policy express Sentara Health Plan’s determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to “correct or ameliorate” (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination,

regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Panniculectomy, abdominoplasty, liposuction, surgical 14, weight loss, panniculus, diastasis recti, bariatric surgery, body mass index