Sentara Health Plans

Medicaid

Surgical Assisted Liposuction, Surgical 131

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Effective Date	12/1/2025
Next Review Date	8/2026
Coverage Policy	Surgical 131
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.

Description & Definitions:

Surgical Assisted Protein Liposuction is a surgery that uses a cannula inserted under the skin to remove excess fatty tissue and fat deposits from an area of the body.

Lipedema is associated with abnormal fat deposition and is characterized by symmetric enlargement of the limbs, combined with tenderness and easy bruising. Treatment includes weight loss, compression, and surgery (liposuction).

Lymphedema is chronic condition that causes swelling(edema) due to an accumulation of lymphatic fluid in fatty tissues just under your skin found in different areas of the body. Over time, this can cause fatty tissue and fibrosis to accumulate.

Criteria:

Surgical assisted liposuction is considered medically necessary for **1 or more of the following**:

- For lymphedema post-mastectomy is medically necessary for **ALL** of the following indications:
  - Individual is adult (18 years and older)
  - Individual has primary or secondary lymphedema
  - Edema located on upper extremity
  - Nonpitting edema
  - Limitation or physical function impairment (i.e. difficult movement or performing activities of daily living)
  - Deformity or disfigurement of a body part
  - Pain
  - Individual has history of at least three consecutive months of non-surgical treatment for lymphedema including **1 or more** of the following:

        - Drug therapy
        - Physical therapy
        - Complete Decongestive Therapy (CDT)
        - Combined Physical Therapy (CPT)
        - Complex Decongestive Physiotherapy (CDP)
        - Compression garments
        - Massage/manual therapy
        - Pneumatic compression
        - Exercise program
        - Kinesio taping
        - Elevation
    - Must continue wearing elastic compression garments and compression therapy
- Liposuction for Lipedema is considered reconstructive and medically necessary to treat when **all the following** criteria are met:
    - A diagnosis of Lipedema that meets **ALL** the following criteria:
        - Bilateral symmetric adiposity with minimal involvement of the feet; and
        - Photographs of the area to be treated document disproportional fat distribution consistent with the diagnosis of lipedema; and
        - Failure of the limb adipose hypertrophy to respond to recommended bariatric surgery or other medically supervised weight loss modalities for at least 3 months if BMI >30; and
        - Negative Stemmer Sign; and
        - Nonpitting edema from the lipedema; and
        - Pressure induced pain and tenderness when palpated
    - Failure to respond to 3 or more months of conservative treatment (i.e. compression or manual therapy); and
    - Treatment plan includes **all the following**:
        - Documentation provided by the referring Physician (different from the treating surgeon) confirms that lipedema is an independent cause of interference with activities of daily living and surgery is expected to restore or improve the functional impairment; and
        - Documentation that the liposuction for the extremity or trunk in its entirety will take place within a 12-month period following the initial surgical treatment unless medically contraindicated. If the treatment plan (Liposuction) cannot be completed within a 12-month period for medical reasons, then a new authorization will be required, to include the clinical records of prior completed treatments.
        - When more than one procedure is necessary on the same region of the extremity and/or trunk (e.g., anterior or posterior of the trunk, upper and lower area of the extremity), documentation that the liposuction volume exceeds a clinically acceptable amount for one surgery (more than 5000 cc total aspirate) and number of planned procedures must be provided.

Surgical assisted liposuction **is NOT COVERED for ANY** of the following:

- Lymphangiosarcoma of the affected arm
- Open wounds in the lymphedematous arm
- To improve the patient's appearance and self-esteem

Document History:

Revised Dates:

- 2025: August – Implementation date of December 1, 2025. Slightly updated criteria for lipedema treatment for clarity. Added definition of lymphedema. Updated to new format. Go live 12.1.2025.
- 2024: November – updated criteria references updated.
- 2024: September – added criteria for the treatment of lipedema and corresponding codes.

Reviewed Dates:

- 2024: August – no changes references updated
- 2023: August

Origination Date: August 2022

Coding:

Medically necessary with criteria:

Coding	Description
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 or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy), other area
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

Considered Not Medically Necessary:

Coding	Description
	None

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

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products: Policy is applicable to Sentara Health Plan Medicaid products.
- Authorization requirements: Pre-certification by the Plan is required.
- Special Notes:
    - Medicaid
        - 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.
- Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

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).

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Keywords:

SHP Surgical Assisted Liposuction for Lymphedema Post-mastectomy, SHP Surgical 131, suction-assisted lipectomy, SAPL, Lymphatic Liposuction