Sentara Health Plans

Medicaid

Surgical Assisted Liposuction for Lymphedema Post-mastectomy

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Effective Date	8/2022
Next Review Date	8/15/2024
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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 be 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 Surgical Assisted Liposuction for Lymphedema Post-mastectomy.

Description & Definitions:

Surgical Assisted Liposuction for Lymphedema Post-mastectomy 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.

Criteria:

Surgical assisted liposuction for lymphedema post-mastectomy is medically necessary for **all of the** following:

- 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

Surgical assisted liposuction for lymphedema post-mastectomy is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

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

Coding:

Medically necessary with criteria:

Coding	Description
15878	Suction assisted lipectomy, upper extremity

Considered Not Medically Necessary:

Coding	Description
	None

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

Document History:

Revised Dates:
Reviewed Dates:

- 2023: August

Effective Date:

- August 2022

References:

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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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:

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