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Panniculectomy
(Abdominal skin/fat surgery)

Date of Origin: 05/2002 **Last Review Date: 06/22/2022** **Effective Date: 07/01/2022**

Dates Reviewed: 02/2004, 12/2004, 12/2005, 12/2006, 12/2007, 01/2009, 02/2011, 01/2012, 07/2013, 06/2014, 05/2015, 06/2016, 06/2017, 08/2018, 08/2019, 07/2020, 07/2021, 06/2022

Developed By: Medical Necessity Criteria Committee

I. Description

Abdominoplasty, often referred to as a tummy tuck, is a surgical procedure for a large, pendulous or protruding abdomen, which tightens lax anterior abdominal wall muscles and removes excess abdominal skin and fat. Traditional abdominoplasty can be performed as an open or endoscopic procedure.

Panniculectomy, a procedure closely related to abdominoplasty, is the surgical excision of an abdominal apron of skin and subcutaneous fat located in the lower abdominal area.

II. Criteria: CWQI HCS-0001

A. OHSU Health Services covers the following procedure for patients who meet **All** of the following criteria:
   a. Panniculectomy will be covered for patients who have undergone substantial weight loss *(usually greater than 100 lbs)* and **ALL** of the following:
      i. The pannus hangs to or below the level of the symphysis pubis as documented in clinical notes
      ii. The patient's weight has remained stable for a period of six months following massive weight loss or if weight loss is a result of bariatric surgery after 12-18 months following surgery
      iii. The panniculus causes chronic intertrigo, candidiasis or tissue necrosis that consistently recurs and has not responded to at least six months of medical treatment with documentation from the treating primary care physician or specialist *(i.e. topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics, meticulous skin care)*
      iv. The pannus causes functional impairment and interferes with activities of daily living
   b. The requests for panniculectomy that do NOT meet the criteria are considered cosmetic and NOT covered.
   c. Repair of the diastasis recti, (defined as a thinning out of the anterior abdominal wall fascia), is NOT covered as clinical literature indicates this does not represent a "true" hernia.
   d. Abdominoplasty is NOT covered as it is considered cosmetic by OHSU Health Services.
   e. Suction assisted lipectomy is NOT covered as it is considered cosmetic by OHSU Health Services.

III. Information Submitted with the Prior Authorization Request:

1. Clinical records from Primary Care Physician or specialist for the past 6 months or 1 year if the procedure is being performed following significant weight loss.
2. Pre-operative photographs that demonstrate the panniculus hangs below the level of the pubic symphysis.

IV. CPT or HCPC codes covered:

Codes	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen; infraumbilical panniculectomy

V. CPT or HCPC codes NOT covered:

Codes	Description
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g. abdominoplasty) (includes umbilical transposition and fascial plication) List in addition to primary code.
15877	Suction assisted lipectomy; trunk

VI. Annual Review History

Review Date	Revisions	Effective Date
07/2013	Annual Review: Added table with review date, revisions, and effective date. Added photo documentation to criterion I, 1.	07/2013
06/2014	Annual Review: Added documentation from treating PCP or dermatologist; added repair of diastasis recti considered cosmetic	06/14
05/2015	Annual Review: Included Medicare guidelines, added ICD-9 codes and ICD-10 codes	
06/2016	Removed ICD-9 codes	6/29/2016
06/2017	Annual review: Updated to new template	06/28/2017
8/2018	Annual review: Removed photo requirement for intertrigo and changed 100 lb weight loss to substantial weight loss usually greater than 100 lbs	08/22/2018
08/2019	Annual review: No changes	09/01/2019
07/2020	Annual review: No changes	08/01/2020

07/2021	Annual Review: Title updated to align with policy indications	08/01/2021
06/2022	Annual Review: No changes	07/01/2022

VII. References

1. ASPS recommended insurance coverage criteria for third-party payers. Surgical treatment of skin redundancy for obese and massive weight loss patients [Internet] Arlington Heights, IL: American Society of Plastic Surgeons January 2007. Accessed February 4. 2011 at: http://www.plasticsurgery.org/Documents/Medical_Profesionals/Surgical-Treatment-of-Skin-Redundancy-Following.pdf
2. ASPS recommended insurance coverage criteria for third-party payers. Abdominoplasty and panniculectomy unrelated to obesity or massive weight loss [Internet] Arlington Heights, IL: American Society of Plastic Surgeons 2007 Jan [accessed 2009 Oct 15] Accessed February 4,2011 at: http://www.plasticsurgery.org/Documents/Medical_Profesionals/AbdominoplastyAndPanniculectomy.pdf
3. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. The evidence report [Internet] Bethesda, MD: National Heart Lung and Blood Institute 1998 Accessed February 4, 2011at: http://www.nhlbi.nih.gov/guidelines/obesity/obesity2/index.htm
4. Fraccalvieri M, et al. Abdominoplasty after weight loss in morbidly obese patients: a 4-year clinical experience. Obesity Surgery 2007;17(10):1319-24. DOI: 10.1007/s11695-007-9235-7
5. Centers for Medicare & Medicaid Services; CMS; Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery L30733; Wisconsin Physicians Service Insurance Corporation;
6. Physician Advisors

Appendix 1 – Covered Diagnosis Codes

ICD 10 code	ICD 10 Code Description
E66.9	Obesity, unspecified
E66.01	Morbid (severe) obesity due to excess calories
E66.3	Overweight
E65	Localized adiposity
L26	Exfoliative dermatitis
L30.4	Erythema intertrigo
L53.8	Other specified erythematous conditions
L92.0	Granuloma annulare
L95.1	Erythema elevatum diutinum
L98.2	Febrile neutrophilic dermatosis [Sweet]

Appendix 1 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD):

Jurisdiction(s): 5, 8	**NCD/LCD Document (s):**

NCD/LCD Document (s):

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC