Panniculectomy and Body Contouring Procedures (for Louisiana Only)

Guideline Number: CS093LA.~~P~~Q
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➲ Instructions for Use

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Application

This **Medical Policy** only applies to the state of Louisiana.

Coverage Rationale

~~**Indications for Coverage**~~

~~**The following are eligible for coverage when the below criteria are met.**~~

~~**Panniculectomy when all of the following criteria have been met:**~~

- ~~Panniculus hangs at or below symphysis pubis~~
- ~~The Panniculus, when present, is the primary cause of skin conditions such as cellulitis requiring systemic antibiotics or transdermal skin ulcerations that have failed to respond to at least 3 months of nonsurgical treatment]~~
- ~~There is presence of a Functional Impairment (interference with activities of daily living) due to the Panniculus~~
- ~~The surgery is expected to restore or improve the Functional Impairment~~

Panniculectomy

Panniculectomy is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Panniculectomy, Abdominal.

Click here to view the InterQual® criteria

~~**Notes:**~~

- ~~After Significant Weight Loss Unrelated to Bariatric Surgery: In addition to the criteria listed above, there must be documentation that a stable weight has been maintained for six months.~~

Panniculectomy Subsequent to Bariatric Surgery

Panniculectomy after bariatric surgery is considered medically necessary when all of the following criteria are met:

- **The beneficiary had bariatric surgery at least 18 months prior and the beneficiary's weight has been stable for at least 6 months; and**
- **The pannus is at or below the level of the pubic symphysis; and**
- **The pannus causes significant consequences, as indicated by at least one of the following:**
  - **Cellulitis, other infections, skin ulcerations, or persistent dermatitis that has failed to respond to at least 3 months of non-surgical treatment; or**
  - **Functional impairment such as interference with ambulation.**

- ~~After Significant Weight Loss Following Bariatric Surgery: In addition to meeting the criteria listed above, there must be documentation that a stable weight has been maintained for six months. This often occurs 12-18 months after surgery~~.

Liposuction for Lipedema

For information on liposuction for lipedema, refer to the Medical Policy titled Liposuction for Lipedema (for Louisiana Only)

~~Liposuction for Lipedema may be considered reconstructive and medically necessary to treat Functional Impairment when criteria and documentation requirements are met.~~

Body Contouring Procedures

Body contouring procedures, including but not limited to the following, are considered cosmetic and not medically necessary:

- **Abdominoplasty**
- **Lipectomy, including Suction-Assisted Lipectomy, (unless part of an approved procedure). For post-mastectomy refer to the Medical Policy titled Breast Reconstruction (for Louisiana Only).**
- **Repair of Diastasis Recti**

~~Documentation Requirements~~

~~Medical notes documenting the following, when applicable:~~

- ~~Primary complaint, history of complaint, and physical exam~~
- ~~Intertriginous rashes or other skin problems with documentation of treatment and response~~
- ~~Functional limitations due to pannus~~
- ~~High-quality color photographs. For panniculectomy, photographs of a full-frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows any skin damage can be evaluated, and a full-lateral view of the hanging pannus~~

- Note: All photographs must be labeled with the:
  - Date taken
  - Applicable case number obtained at time of notification, or the member's name and ID number on the photographs
- Diagnostic photographs can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted

Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.
- Procedures that do not meet the reconstructive criteria in the Indications for Coverage section.
- Body Contouring procedures, including but not limited to:
  - Abdominoplasty
  - Lipectomy when performed on any site including (not an all-inclusive list):
    - Abdomen
    - Arms
    - Buttocks
    - Legs
    - Medial thigh
    - Neck
    - Trunk
  - Panniculectomy (not an all-inclusive list):
    - When performed to relieve neck or back pain as there is no evidence that reduction of redundant skin and tissue results in less spinal stress or improved posture/alignment
    - When performed in conjunction with abdominal or gynecologic surgery including (not an all-inclusive list):
      - Hernia repair
      - Obesity surgery
      - C-section and hysterectomy (unless the member meets the criteria for Panniculectomy as stated above in this document)
    - Performed post childbirth in order to return to pre-pregnancy shape
    - Performed for:
      - Intertrigo
      - Superficial inflammatory response
      - Any other condition that does not meet the criteria above in this document
  - Repair of Diastasis Recti

Suction-assisted lipectomy (unless part of an approved procedure). For post-mastectomy, refer to the Coverage Determination Guideline titled Breast Reconstruction Post Mastectomy and Poland Syndrome (for Louisiana Only)

Definitions

Check the definitions within the federal, state, and contractual requirements that supersede the definitions below.

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 plication of the rectus muscle diastasis and a neoumbilicoplasty.

~~**Belt Lipectomy:** 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.~~

~~**Circumferential Lipectomy:** Combines an Abdominoplasty with a "back lift," both procedures being performed together sequentially and including suction assisted lipectomy, where necessary.~~

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Diastasis Recti: ~~A thinning of the linea alba in the epigastrium and is manifested as a smooth midline protrusion of the anterior abdominal wall. The transversalis fascia is intact, and hence this is not a hernia. There are no identifiable fascial margins and no risk for intestinal strangulation. The presence of Diastasis Recti may be particularly noticeable to the patient on straining or when lifting the head from the pillow. Appropriate treatment consists of reassurance of the patient and family about the innocuous nature of this condition.~~**A vertical abnormal separation of the rectus abdominis muscles (Olsson et al., 2021).**

Functional or Physical or Physiological Impairment: A Functional or Physical or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

~~**Lipedema:** An adipose tissue disorder affecting nearly 1 in 9 adult women. It is characterized as a disproportionate deposit of subcutaneous fat on the buttocks, hips and lower extremities and may affect the arms (Buck, 2017). Symptoms may include physical functional impairment (e.g., difficulty ambulating or performing activities of daily living), pain and tenderness upon pressure, bilateral and symmetrical manifestation with minimal involvement of the feet, bruising, minimal pitting edema, negative stemmer sign, and failure to respond to extreme weight loss modalities (Wold, 1951). Additional symptoms may include hypothermia of the skin, telangiectasias, or swelling that worsens with orthostasis during summer months (Herbst, 2012).~~

~~**Liposuction Suction-Assisted Lipectomy:** Suction-assisted lipectomy (SAL), traditionally known as liposuction, is a method of removing unwanted fatty deposits from specific areas of the face and body. The surgeon makes a small incision and inserts a cannula attached to a vacuum device that suctions out the fat. Areas suitable for liposuction include the chin, neck, cheeks, upper arms, area above the breasts, the abdomen, flanks, the buttocks, hips, thighs, knees, calves and ankles. Liposuction can improve body contour and provide a sleeker appearance. Surgeons may also use liposuction to remove lipomas (benign fatty tumors) in some cases.~~

~~**Lower Body Lift:** 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.~~

~~**Mini or Modified Abdominoplasty:** Typically performed 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 plication, neoumbilicoplasty or flap elevation. A cosmetic Abdominoplasty is sometimes performed at the time of a functional Panniculectomy **(ASPS, 2017)**.

~~**Panniculus:** A medical term describing a dense layer of fatty tissue growth, usually in the abdominal cavity. It can be a result of morbid obesity and can be mistaken for a tumor or hernia.~~

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition
- Improvement or restoration of physiologic function

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Sickness: Physical illness, disease or Pregnancy. The term Sickness includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Suction-Assisted Lipectomy: Suction-Assisted Lipectomy (SAL), ~~traditionally~~more commonly known as Liposuction, is an outpatient procedure that removes adipose tissue from the subcutaneous space with the goal of achieving a more desirable body contour (Wu et al., 2020)~~a method of removing unwanted fatty deposits from specific areas of the face and body. The surgeon makes a small incision and inserts a cannula attached to a vacuum device that suctions out the fat. Areas suitable for liposuction include the chin, neck,~~

~~cheeks, upper arms, area above the breasts, the abdomen, flanks, the buttocks, hips, thighs, knees, calves and ankles. Liposuction can improve body contour and provide a sleeker appearance. Surgeons may also use liposuction to remove lipomas (benign fatty tumors) in some cases.~~

~~**Torsoplasty:** 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 of gynecomastia by suction assisted lipectomy/ultrasound assisted lipectomy or excision.~~

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
The following codes are considered cosmetic; the codes do not improve a functional, physical or physiological impairment	
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

CPT Code	Description
*15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
*15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15876	Suction assisted lipectomy; head and neck

Codes labeled with an asterisk(*) are not on the state of Louisiana Fee Schedule and therefore not covered by the State of Louisiana Medicaid Program.

Description of Services

An abdominal panniculus is an apron of skin and fat that hangs down from the abdomen. This often occurs following massive weight loss and can lead to skin infections, rashes, and difficulty completing activities of daily living (Sachs et al. 2021). A panniculectomy is a surgery that removes this excess skin and fat but typically does not involve the abdominal muscles (ASPS, 2017).

Body contouring is a collection of procedures to change the shape of the body. Adipose tissue is usually removed, with or without removal of excess skin. Body contouring procedures can be either invasive or nonsurgical.

Clinical Evidence

Panniculectomy

Elhage et al. (2021) evaluated the outcomes and quality of life (QOL) in patients undergoing complex abdominal wall reconstruction (AWR) with panniculectomy utilizing 3D volumetric-based propensity match in a prospective cohort study. A prospective database from a tertiary referral hernia center was queried for patients undergoing open AWR. 3D CT volumetrics were analyzed and a propensity match comparing AWR patients with and without panniculectomy was created including subcutaneous fat volume (SFV). QOL was analyzed using the Carolinas Comfort Scale. Propensity match yielded 312 pairs, all with adequate CT imaging for volumetric analysis. The panniculectomy group had a higher BMI ($p = 0.03$) and were more likely female ($p < 0.0001$), but all other demographics and comorbidities were similar. The panniculectomy group was more likely to have undergone prior hernia repair (77% vs 64%, $p < 0.001$), but hernia area, SFV, and CDC wound class were similar (all $p > 0.05$). Requirement of component separation (61% vs 50%, $p = 0.01$) and mesh excision (44% vs 35%, $p = 0.02$) were higher in the panniculectomy group, but operative time were similar (all $p \geq 0.05$). Panniculectomy patients had a higher overall wound occurrence rate (45% vs 32%, $p = 0.002$) which was differentiated only by a higher rate of wound breakdown (24% vs 14%, $p = 0.003$); all other specific wound complications were equal (all $p \geq 0.05$). Hernia recurrence rates were similar (8% vs 9%, $p = 0.65$) with an average follow-up of 28 months. Overall QOL was equal at 2 weeks, and 1, 6, and 12 months (all $p \geq 0.05$). The authors concluded that despite panniculectomy patients and their hernias being more complex, concomitant panniculectomy increased wound complications but did not negatively impact infection rates or long-term outcomes and recommended concomitant panniculectomy be considered in appropriate patients to avoid two procedures.

In a retrospective cohort study, Gebran et al. (2021) evaluated the risk profile of panniculectomy when performed in select patients at the time of bariatric surgery. The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) database (2016-2017), in which data on 379,544 bariatric surgeries were reported was examined. Concurrent panniculectomy procedures were identified by Current Procedural Technology (CPT) codes. Patient characteristics and in-hospital as well as 30-day complications were compared between the body contouring group and propensity score-matched bariatric surgery controls. One hundred twenty-four patients met inclusion criteria and were matched to 248 controls. An infra-umbilical panniculectomy was performed in the majority of patients (n = 94, 75.8%). Most patients received an open rather than laparoscopic bariatric surgery (n = 87, 70.2%). There were no statistically significant differences between 30-day mortality (1.9%), wound complications (11.5%), readmission (12.5%) and reoperation (5.8%) between the 2 groups (p > .05). Wound complications occurred in 11.5% of patients and were associated with prolonged hospital stay (odds ratio 4.65, 95% confidence interval 1.99–10.86, p < .001) and a body mass index (BMI) > 50 (odds ratio 3.19, 95% confidence interval 1.02–9.96, p = .046). The authors concluded, in select patients, panniculectomy at the time of bariatric surgery was not associated with increased in-hospital or 30-day adverse outcomes compared with matched bariatric surgery controls, however, revision surgery may be needed once weight loss stabilizes. The study was limited by database limitations, short-term follow up, and multiple outcome variables.

Nag et al. (2021) performed a retrospective cohort study and systematic review to evaluate the premise that the addition of panniculectomy to gynecologic surgery in the obese and morbidly obese patient population results in a statistically significant improvement in measurable outcomes. The American College of Surgeons National Surgical Quality Improvement Program (NSQIP) database was reviewed to assess the association of complications with panniculectomy combined with gynecologic surgery in the morbidly obese patient population. The query identified 296 patients with a body mass index greater than 30 who had panniculectomy concomitant with gynecologic surgery. The results demonstrated a statistically significant relationship ($p < 0.05$) of these concomitant procedures with superficial infection, wound infection, pulmonary embolism, systemic sepsis, return to operating room, length of operation and length of stay. A systematic review of the literature was then performed which identified only 5 studies that included comparative cohorts of those with gynecologic surgery, with and without panniculectomy. There was no significant benefit across the studies in measured parameters. The authors concluded that there was no statistically significant benefit associated with performing panniculectomy in conjunction with gynecologic surgery in the morbidly obese patient population and that there was significant elevation of negative outcomes in morbidly obese patients undergoing combined procedures.

In a systematic meta-analysis, Prodromidou et al. (2020) assessed the current knowledge concerning the safety and efficacy of combining panniculectomy in surgical management of endometrial cancer (EC) in obsess patients. Four electronic databases were systematically searched for articles published up to May 2019. A total of five studies, of which two were non-comparative and three comparative, were included. Meta-analysis of complications among panniculectomy and conventional laparotomy group revealed no difference in either intra- or post-operative complication rates. Moreover, no difference was reported in surgical site complications (p=0.59), while wound breakdown rates were significantly elevated in the laparotomy group (p=0.02). The authors concluded panniculectomy combined surgery for the management of EC can be considered a safe procedure in selected patients and presents with comparable outcomes to conventional laparotomy procedures with regard to non-surgical and surgical site complications and improved wound breakdown rates. The

authors noted that the outcomes must be cautiously interpreted because of the limited number of studies included in this meta-analysis and their retrospective nature.

Sosin et al. (2020) conducted a systematic meta-analysis to assess the durability, complication profile, and safety of simultaneous ventral hernia repair and panniculectomy (SVHRP) through a large data-driven repository of SVHRP cases. The current SVHRP literature was queried using the MEDLINE, PubMed, and Cochrane databases. Predefined selection criteria resulted in 76 relevant titles yielding 16 articles for analysis. Meta-analysis was used to analyze primary outcomes, identified as surgical-site occurrence and hernia recurrence. Secondary outcomes included review of techniques used and systemic complications, which were analyzed with pooled weighted mean analysis from the collected data. There were 917 patients who underwent an SVHRP (mean age, 52.2 ± 7.0 years; mean body mass index, 36.1 ± 5.8 kg/m; mean pannus weight, 3.2 kg). The mean surgical-site occurrence rate was 27.9% (95% CI, 15.6 to 40.2%; I = 70.9%) and the mean hernia recurrence rate was 4.9% (95% CI, 2.4 to 7.3%; I = 70.1%). Mean follow-up was 17.8 ± 7.7 months. The most common complications were superficial surgical-site infection (15.8%) and seroma formation (11.2%). Systemic complications were less common (7.8%), with a thromboembolic event rate of 1.2%. The overall mortality rate was 0.4%. The authors concluded SVHRP is associated with a high rate of surgical-site occurrence, but surgical-site infection seems to be less prominent than previously anticipated. The authors indicated the low hernia recurrence rate and the safety of this procedure support its current implementation in abdominal wall reconstruction. (McNichols et al., 2018 is included in this review)

In a retrospective cohort study, Diaconu et al. (2019) compared outcomes in obese patients who undergo ventral hernia repair with concurrent panniculectomy versus ventral hernia repair alone. Postoperative complications were compared between patient who underwent concurrent panniculectomy and those who did not. A total of 223 patients were analyzed: 122 in the ventral hernia repair with concurrent panniculectomy group and 101 in the ventral hernia repair-only group. Median follow-up duration was 141 days. Patients in the ventral hernia repair with concurrent panniculectomy group had more surgical-site occurrences (57 percent versus 40 percent; p = 0.012). Both groups had similar rates of surgical-site occurrences that required an intervention (39 percent versus 31 percent; p = 0.179) and similar rates of hernia recurrence (23 percent versus 29 percent; p = 0.326). Multivariate analysis showed that concurrent panniculectomy increased the risk of surgical-site occurrences by two-fold; however, it did not increase the risk of surgical-site occurrences that required an intervention. The authors concluded the addition of a panniculectomy to ventral hernia repair increases surgical-site occurrences but does not increase complications that require an intervention.

McNichols et al. (2018) conducted a retrospective case series review of patients from the University of Maryland Medical Center to review the risks and benefits of combined ventral hernia repair and panniculectomy (VHR/PAN). A retrospective database was collected using current procedural terminology codes for VHR/PAN. The patient-specific variables that were studied include the following: sex, body mass index (BMI), smoking, diabetes, chronic obstructive pulmonary disease, cirrhosis, immunosuppression, length of operation, acute incarcerated hernias, hernia size and location, mesh size and location, pannus weight, concomitant component separation, use of negative-pressure wound therapy, intestinal violation, follow-up duration, ventral hernia working group, history of bariatric surgery, previous hernia repair, skin dehiscence, skin necrosis, chronic wound, surgical site infection, seroma, hematoma, fascial dehiscence, hernia recurrence, unplanned return to operating room, and medical complication. Both univariate and multivariate analyses were performed to determine which factors affected the complication

outcomes. There were 106 patients with an average age and BMI of 53 years and 39, respectively. Fifty-eight patients (54.72%) had at least 1 surgical site occurrence. Twenty-three patients (21.70%) had at least 1 repair failure. Twenty-eight patients (26.42%) had an unplanned trip back to the operating room. Seventeen patients (16.04%) had at least 1 medical complication. The authors concluded the risk factors associated with developing complications are higher BMI, longer operating time, larger mesh size, larger hernia size, component separation, use of biologic mesh, chronic obstructive pulmonary disease, and intestinal violation. The use of negative-pressure wound therapy decreased complication rates, and patients with a previous hernia repair seemed to benefit the most from having a combined VHR/PAN. The authors concluded, when compared with previous reports of VHR alone, VHR/PAN does seem to increase wound complications and reoperation rates.

Fennimore et al. (2015) conducted a retrospective cohort study to determine whether a modified abdominal panniculectomy at the time of cesarean delivery decreases wound complications in morbidly obese women. The study included 59 morbidly obese patients who delivered via cesarean section at a single center between 2003 and 2009. A total of 30 morbidly obese patients who underwent modified panniculectomy at the time of cesarean section were compared to a control group of 29 morbidly obese women who underwent cesarean section alone. Of the 30 women who underwent modified panniculectomy at the time of cesarean, 3% (n = 1) developed operative site infection that required readmission. In the control group, 24% (n = 7) developed operative site infection (p = 0.026), and 10% (n = 3) were readmitted (p = 0.35). There was no difference in the postpartum length of hospital stay, intraoperative blood loss, operative time and infant delivery time between the two groups. In the cohort, morbidly obese women who underwent panniculectomy at the time of cesarean section had lower incidence of wound complications without significant increase in operative time, hospital length of stay, and infant delivery time. The authors concluded modified panniculectomy at the time of cesarean may be a useful adjunct in an effort to decrease postoperative infectious morbidity in obese patients, however, the effects of the procedure on long-term healing, future obstetric outcomes, and other medical conditions warrant further evaluation.

Clinical Practice Guidelines

American Society of Plastic Surgeons (ASPS)

ASPS (2019) recommends 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. ASPS further recommends that a 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.

In a practice parameter, ASPS (2017) noted panniculectomy could be considered as a functional correction in patients who are of appropriate height and weight, and have a history of problems including panniculitis or chronic back pain that have persisted despite an adequate trial of non-surgical management, or have a functional impairment in

activities of daily living/work, etc. ASPS notes a strong relationship between increased BMI and surgical complication across the surgical spectrum. Acarturk et al. (2004) retrospectively compared the surgical outcomes of 21 patients that had simultaneous panniculectomy and bariatric surgery to 102 patients that delayed panniculectomy following bariatric surgery by a mean of 17 months. Those who had simultaneous surgery had significantly more complications and higher mortality.

Society of Obstetricians and Gynaecologists of Canada (SOGC)

SOGC clinical practice guideline for gynecologic surgery for patients with obesity (Yong et al., 2019) reviews the evidence for panniculectomy performed concurrently with gynecologic surgeries. The guideline notes that studies in this area have been primarily small, retrospective, and/or non-comparative studies. The authors indicated that panniculectomy can be considered at the time of open hysterectomy in patients with obesity, although it is rarely performed; and when a combined procedure is done, consideration should be given to postoperative antibiotics.

Body Contouring

Body contouring procedures are typically performed for cosmetic purposes. Body contouring procedures can include, but are not limited to, abdominoplasty, lipectomy, and body lifts. Procedures are often combined for a more global aesthetic improvement (Shermak, 2020).

Jiang et al. (2021) noted many post-bariatric patients have impaired health-related quality of life (HRQoL) due to excess skin following weight loss; however, it is inconclusive whether body contouring surgery (BCS) improves this impairment. In a systematic review, the authors summarized existing evidence of the effect of BCS on HRQoL and determine the prevalence of, the desire for, and barriers to BCS (secondary outcomes). Randomized controlled trials, cohort, cross-sectional, case-control, and longitudinal studies were systematically searched in PubMed, Embase, the Cochrane Central, and Web of Science. After screening 1923 potential records, 24 studies (representing 6867 participants) were deemed eligible. Only 18.5% of respondents from cross-sectional studies underwent BCS, with abdominal BCS as the most common procedure. Most participants desired BCS but listed "cost" and "lacking reimbursement" as the main barriers. The authors concluded the results suggest that most post-bariatric patients who underwent BCS experienced improvements in their HRQoL, which could be seen in almost every dimension evaluated, including body image and physical and psychosocial functions. The authors recommended both bariatric and plastic surgeons should regard BCS not only as an aesthetic supplement but also as a vital part of functional recovery in the surgery-mediated weight loss journey and, thus, provide it to more post-bariatric patients.

Olsson et al. (2021) performed a systematic review to analyze the outcomes of rectus diastasis (RD) repair, focusing on functional changes following surgery. A comprehensive search in PubMed and Web of Science was performed. Suitable papers were selected using titles and abstracts with terms suggesting surgical treatment of RD. All abstracts were scrutinized, and irrelevant studies excluded in four stages. Reports providing original data, including outcome assessment following surgery, were included. Ten papers with a total of 780 patients were found to fulfil the search criteria. Study design, surgical procedure, follow-up time, functional outcome and assessment instruments were compiled. All included studies reported improvements in a variety of functional aspects regardless of surgical method. The outcomes assessed include core stability, back pain, abdominal pain, posture, urinary incontinence, abdominal muscle strength and quality of life. The authors concluded that the review showed surgical repair of RD is a safe and effective

treatment that improves functional disability, however, the absence of standardized instruments for assessing outcome makes it impossible to compare studies. Since indications for surgery are relative and related to core function, the authors recommended valid instruments for assessing indication and outcome are needed to ensure benefit of the procedure. The study was limited by the number of studies included in the review and a low level of evidence in some of the included studies.

In a systematic review, Gormley et al. (2020) reviewed the effect of rectus plication on abdominal strength, function, and postoperative complications. A comprehensive search of CINAHL, Embase, Medline and Web of Science was performed. Screening and data extraction were performed in duplicate. Data were extracted from the included articles, and outcomes were analyzed categorically. A total of 497 patients from seven articles were included. Mean age was 44.5 years (range 20.5-72) and 94.4% were female. Three articles reported abdominal strength measurements, with two showing significant improvement. Four articles used the SF-36 survey, all demonstrating improvement in physical function subscale postoperatively. An additional six instruments were used to assess functional outcomes, of which four demonstrated significant improvement. The overall complication rate was 17.0%. The authors noted rectus plication is commonly performed during abdominoplasty to improve abdominal form and function. They concluded that while the literature to date is encouraging with respect to functional outcomes, improvements in abdominal strength are less consistent. Heterogeneity in patient population, outcome measures, and comparison groups limit the strength of the authors' conclusions. The authors recommend future research should include a large comparative study as well as a protocol for standardizing outcomes in this population.

Wu et al. (2020) note liposuction is the second most commonly performed cosmetic surgery in the United States. Suction-assisted lipectomy, more commonly known as liposuction, is an outpatient procedure that removes adipose tissue from the subcutaneous space with the goal of achieving a more desirable body contour. It is the second most commonly performed cosmetic surgery in the United States and the most common surgical procedure in patients between the ages of 35 and 64. Liposuction is used to achieve body contouring by removing excess fat deposits in undesirable areas of the body. Fat is suctioned from demarcated areas in the body amenable to contouring. Liposuction is also increasingly being used as an adjunct to enhance other aesthetic procedures such as breast augmentation, cervicoplasty, abdominoplasty, gluteal fat transfer, and body contouring for postsurgical bariatric patients. Noncosmetic indications are expanding, particularly fat grafting for breast, facial, and pedal reconstruction.

Akram et al. (2014) investigated indications for surgical repair of RD in a systematic review. The authors presented classifications of RD, current knowledge on the relation to pregnancy, and conservative and surgical management. A systematic search in PubMed, Embase, Cochrane, and CINAHL revealed 437 studies. Inclusion criteria were applied according to the above mentioned subjects of interest. In total 28 studies were included, representing 3725 patients, 11 of these by assessing reference lists of included studies. Only one RCT was found; most studies were case-series lacking statistical analysis. RD was common in post-partum women. Antepartum activity level may have a protective effect on RD and exercise may improve post-partum symptoms of RD. Repair was done during abdominoplasty or laparoscopically. The patient-satisfaction was high and long-term recurrence was reported by one study, while five reported no recurrence. Overall major complications were few, while minor complications were primarily seroma and wound complications. RD is by itself not a true hernia and, therefore, not associated with the risk of strangulation. The authors conclusions included repair is mostly done due to cosmetic reasons, the condition does not necessarily require repair, and conservative

management may be an alternative. The authors further note that, if done, the protrusion of the abdomen, rather than the diastasis itself should influence the decision of repair. The authors recommended that future studies use the established classifications (e.g. Beer, Rath, or Nahas) when reporting RD and long-term outcome of treatment. Comparison of surgical techniques and studies that address and compare conservative management with surgery are needed.

Staalesen et al. (2012) performed a systematic review to evaluate the quality of evidence of benefits and risks for patients having abdominoplasty from massive weight loss or childbirth. Outcome measures were quality-of-life, respiratory function, back pain, and complication rates. PubMed, Cochrane Database of Systematic Reviews, CRD, CINDAHL, AMED, PsycINFO and different Health technology Assessment organizations (SBU, Kunnskapssenteret, Sundhetsstyrelsen) were searched for articles published until October 2011. Inclusion criteria were studies written in English or Scandinavian language including at least 30 patients with a control group and a case series of at least 100 patients. Review articles and case studies were excluded. The scientific level of evidence was evaluated using the GRADE-system. One small controlled study on abdominoplasty was found indicating a positive effect on quality-of-life. No controlled studies evaluating the other outcomes respiratory function and back pain were found. One prospective study reported minor complications averaging to 25%. Fourteen retrospective studies reported the same pattern. The major complication venous thromboembolism was found in 2%-8% in three series. The authors concluded that the quality of evidence of positive health effects for patients having abdominoplasty is very low concerning all studied outcomes.

Clinical Practice Guidelines

American Society of Plastic Surgeons (ASPS)

ASPS (2016) states abdominoplasties are typically performed for purely cosmetic indications such as unacceptable appearance due to fat maldistribution or contour deformities caused by pregnancy, stretch marks, contracted scars, and loose hanging skin after weight loss.

In a practice parameter, ASPS (2017) indicates the timing for body contouring surgery is ideally performed after the patient maintains a stable weight for 2 to 6 months. For post bariatric surgery patients, this often occurs 12-18 months after surgery or at the 25 kg/mg^2 to 30 kg/mg^2 weight range. Sometimes procedures are staged. An initial functional panniculectomy with limited tissue undermining and/or reduction mammaplasty may be necessary to increase the patient's comfort and facilitate the ease of exercise and further weight loss. Once the patient approaches his/her ideal body weight more refined body contouring surgery may be performed to address aesthetic issues.

ASPS (2017) indicates deformities associated with massive weight loss vary greatly depending on the patients' body type, their fat deposition pattern, and the amount of weight gained or lost. These deformities can lead to patient dissatisfaction with appearance, inability to exercise, impaired ambulation, chronic back, neck and shoulder pain, difficulty with hygiene and symptoms such as uncontrolled intertrigo, infections, and skin necrosis. A panniculectomy or abdominoplasty alone will eliminate the large hanging abdominal panniculus and its associated symptomatology, but may leave redundant tissue known as "dog ears" posterior to the excision. Circumferential approaches such as belt lipectomy, and circumferential lipectomy provide a superior aesthetic result because the anterior deformities as well as back and side rolls are addressed and the buttocks

lifted. Abdominoplasty and circumferential lipectomy typically would be considered cosmetic procedures.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Panniculectomy and body contouring procedures are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. See the following website for additional information: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed February 7, 2022)

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Policy History/Revision Information

Date	Summary of Changes

TBD	**Template Update**
	• Changed policy type classification from "Coverage Determination Guideline" to "Medical Policy"
	Coverage Rationale
	• Removed list of documentation requirements
	• Removed language pertaining to coverage limitations and exclusions
	Panniculectomy
	• Revised language to indicate Panniculectomy is considered reconstructive and medically necessary in certain circumstances; refer to the InterQual® CP: Procedures, Panniculectomy, Abdominal for medical necessity clinical coverage criteria
	Panniculectomy Subsequent to Bariatric Surgery
	• Revised language to indicate Panniculectomy after bariatric surgery is considered medically necessary when all of the following criteria are met:
	  ○ The beneficiary had bariatric surgery at least 18 months prior and the beneficiary's weight has been stable for at least 6 months; and
	  ○ The pannus is at or below the level of the pubic symphysis; and
	  ○ The pannus causes significant consequences, as indicated by at least one of the following:
	  ▪ Cellulitis, other infections, skin ulcerations, or persistent dermatitis that has failed to respond to at least 3 months of non-surgical treatment; or
	  ▪ Functional impairment such as interference with ambulation
	Liposuction for Lipedema
	• Removed coverage statement; refer to the Medical Policy titled *Liposuction for Lipedema (for Louisiana Only)* for applicable information
	Body Contouring Procedures
	• Revised language to indicate body contouring procedures are considered cosmetic and not medically necessary including, but not limited to, the following:
	  ○ Abdominoplasty
	  ○ Lipectomy, including Suction-Assisted Lipectomy (unless part of an approved procedure); for post-mastectomy, refer to the Medical Policy titled *Breast Reconstruction (for Louisiana Only)*
	  ○ Repair of Diastasis Recti
	Definitions
	• Updated definition of:
	  ○ Diastasis Recti
	  ○ Suction-Assisted Lipectomy
	• Removed definition of:
	  ○ Belt Lipectomy
	  ○ Circumferential Lipectomy
	  ○ Lipedema
	  ○ Lower Body Lift
	  ○ Mini or Modified Abdominoplasty
	  ○ Panniculus
	  ○ Torsoplasty
	Applicable Codes

Date	Summary of Changes
	• Added notation to indicate CPT codes 15836, 15837, 15838, and 15839 are not on the state of Louisiana Fee Schedule and therefore are not covered by the State of Louisiana Medicaid Program **Supporting Information** • Added *Description of Services*, *Clinical Evidence*, and *FDA* sections • Updated *References* section to reflect the most current information • Archived previous policy version CS093LA.P

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.