

## MEDICAL POLICY

|               |                                   |
|---------------|-----------------------------------|
| POLICY TITLE  | ABDOMINOPLASTY AND PANNICULECTOMY |
| POLICY NUMBER | MP 1.012                          |

|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CLINICAL BENEFIT | <input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN.<br><input type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS.<br><input checked="" type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE.<br><input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS.<br><input type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET.<br><input type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE. |
| Effective Date:  | RETIRED 9/1/2026                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

[POLICY  
RATIONALE  
CODING INFORMATION](#)

[PRODUCT VARIATIONS  
DEFINITIONS  
REFERENCES](#)

[DESCRIPTION/BACKGROUND  
DISCLAIMER  
POLICY HISTORY](#)

### I. POLICY

Panniculectomy may be considered **medically necessary** when **photographs and clinical documentation** show the following:

- The panniculus hangs below the level of the symphysis pubis; **AND** one or more of the following indications are present:
  - o The panniculus has resulted in a severe skin condition that consistently recurs or has failed to respond to prescription oral or topical medications for at least 3 months; **OR**
  - o The panniculus has resulted in severe functional impairment of ADLs (activities of daily living)

Panniculectomy for any other condition is considered **investigational** as there is insufficient evidence to support a general conclusion supporting the health outcomes or benefits associated with this procedure.

Abdominoplasty, with or without panniculectomy, is considered **investigational** as there is insufficient evidence to support a general conclusion supporting the health outcomes or benefits associated with this procedure.

#### **Cross-Reference:**

**MP 1.004 Cosmetic and Reconstructive Surgery**

### II. PRODUCT VARIATIONS

[TOP](#)

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

## MEDICAL POLICY

|               |                                   |
|---------------|-----------------------------------|
| POLICY TITLE  | ABDOMINOPLASTY AND PANNICULECTOMY |
| POLICY NUMBER | MP 1.012                          |

**FEP PPO:** Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:  
<https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies>.

### III. DESCRIPTION/BACKGROUND

[TOP](#)

Panniculectomy is most often associated with a cosmetic procedure to remove unwanted fatty abdominal apron. The redundant apron of skin and fat is due to a lack of underlying supportive tissue and does not respond to weight loss or exercise. This surgery may be considered medically necessary and appropriate under certain circumstances, such as presence of severe pain, dermatitis or ulceration not improved using conventional treatments and requiring reconstructive surgical intervention.

Abdominoplasty is an elective surgical procedure to remove unwanted fatty tissue and/or skin surrounding the abdomen as well as tightening of the musculature and fascia of the abdominal wall.

Panniculectomy or abdominoplasty performed at the time of an abdominal hernia repair has been suggested to reduce the risk of two possible complications. The first is post-operative infection of the surgical incision, due to an environment conducive to bacterial growth in the intertriginous area under the pannus. The other possible complication is an increase in hernia recurrence, due to traction of the pannus on the hernia repair. The risk of these complications has not been clearly demonstrated.

Diastasis recti is a condition characterized by separation between the left and right side of the rectus abdominis however, does not represent a "true" hernia. Surgical procedures such as abdominoplasty may be used to repair diastasis recti.

### IV. RATIONALE

The current medical evidence on the efficacy of panniculectomy primarily comprises individual case reports, large retrospective cohorts, prospective observational studies and review articles. The medical literature consistently demonstrates that a large, overhanging pannus can lead to chronic and recurrent skin conditions—including intertrigo, cellulitis, ulceration, and moisture-associated dermatitis—often fail to resolve with conservative management. Studies also show that removal of the pannus improves mobility, facilitates hygiene, reduces infection frequency, and enhances overall quality of life, particularly in post-bariatric patients who experience excess skin following substantial weight loss. Evidence from retrospective cohorts and patient-reported outcomes supports the procedure's effectiveness in reducing symptoms, improving functional capacity, and decreasing healthcare utilization related to skin complications.

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|               |                                   |
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| POLICY NUMBER | MP 1.012                          |

There is limited evidence to demonstrate any significant health benefits from abdominoplasty for diastasis recti or other indications. Although ample literature illustrates the cosmetic benefits of this procedure, improvements in physical functioning, cessation of back pain, and other positive health outcomes have not been demonstrated. Most of the existing evidence consists of individual case reports focusing primarily on the cosmetic outcomes of the surgery. Currently, there is insufficient evidence to support abdominoplasty for purposes other than cosmetic when done to remove excess abdominal skin or fat, with or without tightening lax anterior abdominal wall muscles.

### V. DEFINITIONS

[Top](#)

**COSMETIC SURGERY** is an elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function but is considered unpleasant or unsightly.

**DIASTASIS RECTI** is the separation of rectus abdominis muscles away from the midline.

**FUNCTIONAL IMPAIRMENT** is a condition that describes a state where an individual is physically limited to perform basic daily activities.

**INTERTRIGINOUS DERMATITIS** is a condition that describes an itchy and red inflammatory rash found under the skin folds often caused by trapped moisture.

**RECONSTRUCTIVE SURGERY** is a procedure performed to improve or correct a functional impairment, restore a bodily function, or correct a deformity resulting from birth defect or accidental injury. The fact that a member might suffer psychological consequences from a deformity does not, in the absence of bodily functional impairment, qualify surgery as being reconstructive surgery.

### V. DISCLAIMER

[Top](#)

*Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.*

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|               |                                   |
|---------------|-----------------------------------|
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| POLICY NUMBER | MP 1.012                          |

### VI. CODING INFORMATION

[TOP](#)

**Note:** This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

#### Covered when medically necessary:

| Procedure Codes |  |  |  |  |  |  |  |  |  |
|-----------------|--|--|--|--|--|--|--|--|--|
| 15830           |  |  |  |  |  |  |  |  |  |

#### Investigational; therefore, not covered for abdominoplasty:

| Procedure Codes |  |  |  |  |  |  |  |  |  |
|-----------------|--|--|--|--|--|--|--|--|--|
| 15847           |  |  |  |  |  |  |  |  |  |

| ICD-10-CM<br>Diagnosis<br>Codes | Description                                                                          |
|---------------------------------|--------------------------------------------------------------------------------------|
| L24.A0                          | Irritant contact dermatitis due to friction or contact with body fluids, unspecified |
| L24.A9                          | Irritant contact dermatitis due friction or contact with other specified body fluids |
| L30.4                           | Erythema intertrigo                                                                  |
| L30.8                           | Other specified dermatitis                                                           |
| L30.9                           | Dermatitis, unspecified                                                              |
| M79.3                           | Panniculitis, unspecified                                                            |

### VII. REFERENCES

[TOP](#)

1. American Society of Plastic Surgeons (ASPS). *ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Surgical Treatment of Skin Redundancy For Obese and Massive Weight Loss Patients.* Updated June 2017
2. American Society of Plastic Surgeons (ASPS). *ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Abdominoplasty* Updated September 2018
3. American Society of Plastic Surgeons (ASPS). *ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Panniculectomy* Updated March 2019
4. Kalmar CL, Park BC, Kassis S, Higdon KK, Perdakis G. Functional panniculectomy vs cosmetic abdominoplasty: Multicenter analysis of risk factors and complications. *J Plast Reconstr Aesthet Surg.* 2022 Sep;75(9):3541-3550. PMID: 35705442
5. Mast BA. Safety and efficacy of outpatient full abdominoplasty. *Ann Plast Surg.* 2005 Mar; 54(3): 256-9
6. Rather, AA. Abdominal hernias. *EMedicine J.* Updated March 16, 2023

## MEDICAL POLICY

|               |                                   |
|---------------|-----------------------------------|
| POLICY TITLE  | ABDOMINOPLASTY AND PANNICULECTOMY |
| POLICY NUMBER | MP 1.012                          |

7. Reichenberger MA, Stoff A, Richter DF. Dealing with the mass: A new approach to facilitate panniculectomy in patients with very large abdominal aprons. *Obes Surg.* 2008;18(12):1605-1610
8. Reid RR, Dumanian GA. Panniculectomy and the separation-of-parts hernia repair: a solution for the large infraumbilical hernia in the obese patient. *Plast Reconstr Surg.* 2005 Sep 15; 116(4): 1006-12
9. Shermak MA. Hernia repair and abdominoplasty in gastric bypass patients. *Plastic & Reconstructive Surgery Plast Reconstr Surg.* 2006 Apr; 117(4): 1145-50; discussion 1151  
*Taber's Cyclopedic Medical Dictionary 19th edition*
10. Sachs D, Sequeira Campos MB, Hattingh G, Murray J. Panniculectomy. In: *StatPearls. Treasure Island (FL): StatPearls Publishing; July 18, 2023*

### IX. POLICY HISTORY

[TOP](#)

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|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MP 1.012 | <b>01/05/2021 Consensus Review.</b> No change to policy statement. References updated.                                                                                                                                                                                                                                                                                                                                                                                                             |
|          | <b>09/07/2021 Administrative Update.</b> New codes added L24.A0 and L24.A9. Effective 10/01/2021                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | <b>02/17/2022 Consensus Review.</b> References updated. Coding reviewed.                                                                                                                                                                                                                                                                                                                                                                                                                           |
|          | <b>02/07/2023 Consensus Review.</b> No change to policy statement. Background updated. References added.                                                                                                                                                                                                                                                                                                                                                                                           |
|          | <b>01/12/2024 Minor Review.</b> Added timeframe of 3 months treatment for panniculectomy skin conditions. Removed conventional treatment requirement from panniculus functional impairment criteria. Added criteria for structural abnormality of abdominal musculature for abdominoplasty criteria. Background updated. References added.                                                                                                                                                         |
|          | <b>01/15/2025 Minor Review.</b> Abdominoplasty changed from medically necessary to investigational. Panniculectomy criteria has been revised to provide a more detailed definition of conservative treatment by including failed response to prescription oral or topical medications, removing criteria related to abdominal surgery and including ADLs (activities of daily living) in the criteria addressing functional impairment. Background, Rationale, Definitions and References updated. |
|          | <b>06/10/2025 Administrative Update.</b> Removing the Benefit Variations and updating the Disclaimer.                                                                                                                                                                                                                                                                                                                                                                                              |
|          | <b>02/11/2026 Retirement.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

[TOP](#)

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