MEDICAL POLICY

POLICY TITLE	**ABDOMINOPLASTY AND PANNICULECTOMY**
POLICY NUMBER	**MP 1.012**

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☒ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**6/1/2024**

I. POLICY

Panniculectomy may be considered **medically necessary** and appropriate when there is documented clinical evidence, **including photographs**, that:

- The panniculus hangs significantly below the level of the symphysis pubis; **AND** one or more of the following indications are present:
  - The presence of the panniculus has resulted in one or more severe symptomatic skin conditions, including but not limited to, severe intertriginous dermatitis, skin ulceration, or other severe skin condition that consistently recurs or has failed to respond to conventional treatment for at least 3 months; **OR**
  - Unrelated or separate abdominal surgery requiring improved surgical access and postoperative wound healing, (for example, repair of a large ventral hernia associated with a large pannus); **OR**
  - The presence of the panniculus has resulted in severe functional impairment.

For abdominoplasty to be considered reconstructive surgery and therefore **medically necessary,** there must be documented clinical evidence, **including photographs**, that demonstrates the presence of **ALL** the following:

- Structural abnormality of the abdominal musculature
- Severe symptomatic skin conditions including, but not limited to, severe intertriginous dermatitis, recurrent skin ulceration, or other severe skin conditions
- The skin condition or functional impairment has failed to respond to conventional treatment.

Panniculectomy or abdominoplasty performed to minimize the risk of a hernia formation is considered **not medically necessary**. Evidence has not shown that a pannus contributes to the hernia formation.

Panniculectomy or abdominoplasty performed for any other reasons than those addressed in the policy or primarily for cosmetic purposes is considered **not medically necessary**.

Abdominoplasty or panniculectomy performed to repair a diastasis recti is considered **not medically necessary.** Diastasis recti is not a true hernia and has no clinical significance.

Cross-reference:
MP 1.004 Cosmetic and Reconstructive Surgery

II. PRODUCT VARIATIONS

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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.

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

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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. Abdominoplasty may be considered medically necessary and appropriate under certain circumstances, as in structural anomaly of the abdominal wall, the presence of severe pain, severe recurrent dermatitis, or ulceration not improved using conventional treatments.

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. DEFINITIONS

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BASIC ACTIVITIES OF DAILY LIVING include and are limited to walking in the home, eating, bathing, dressing, and homemaking.

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.

MORBID OBESITY describes a condition where body mass index is greater than 40kg/m^2.

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. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VI. DISCLAIMER

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Capital Blue Cross' medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are

solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VII. CODING INFORMATION

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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	15847							

ICD-10-CM Diagnosis 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

VIII. REFERENCES

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1. *American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Surgical Treatment of Skin Redundancy Following Massive Weight Loss. Updated June 2017*
2. *American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Abdominoplasty Updated June 2018*
3. *American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Panniculectomy Updated June 2019*
4. *Kalmar CL, Park BC, Kassis S, Higdon KK, Perdikis 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*
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 M, Murray J. Panniculectomy. [Updated 2023 Jul 18]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan*

IX. POLICY HISTORY

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MP 1.012	**01/05/2021 Consensus review.** No change to policy statement. References updated.
	09/07/2021 Administrative update. New codes added L24.A0 and L24.A9. Effective 10/1/2021
	02/17/2022 Consensus review. References updated. Coding reviewed.
	02/07/2023 Consensus review. No change to policy statement. Background updated. References added.
	01/12/2024 Minor review. 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.

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