MetroPlus Health

Policy and Procedure

Title: Abdominoplasty/Panniculectomy	Division: Medical Management Department: Utilization Management
Approval Date: 7/20/17	LOB: Medicaid, Medicare, HIV, SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP, UltraCare
Effective Date: 7/20/17	Policy Number: UM-MP200
Review Date: 7/22/2024	Cross Reference Number:
Retired Date:	Page 1 of 5

1. **POLICY DESCRIPTION:**
   Abdominoplasty/Panniculectomy

2. **RESPONSIBLE PARTIES:**
   Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. **DEFINITIONS:**

   Abdominoplasty: A surgical procedure that tightens the lax anterior abdominal wall and removes excess abdominal skin and other tissue.

   Panniculectomy: The surgical excision of the panniculus (abdominal fat apron). These procedures are deemed cosmetic when performed solely to refine or reshape structures or surfaces that are not functionally impaired. When performed to correct or relieve structural abdominal wall defects that result in significant functional impairment, they are deemed reconstructive.

   Bariatric Surgery: A surgical procedure of the upper gastrointestinal tract that is designed to cause weight loss. Bariatric procedures can be restrictive, malabsorptive, or a combination of both.

   Functional Impairment: Functional impairment refers to an extensive redundancy of skin and fat folds (e.g., a panniculus below the pubis). The development is often secondary to massive weight loss. An abdominal panniculus of this extent is causal to functional impairment.

4. **POLICY:**
   Related Medical Guideline
   Cosmetic Surgery Procedures
   In the case that more than one procedure is to be performed, coverage will only be applicable to the reconstructive procedure; the cost of the cosmetic procedure (i.e., abdominoplasty in association with panniculectomy) will be the responsibility of the member (as per group contract, individual contract or policy). Additionally, photographic evidence must accompany written documentation substantiating medical necessity.

1. Panniculectomy Coverage Criteria
    a. InterQual Guidelines are used by MetroPlus to determine the medical necessity of this procedure.

2. Abdominplasty is considered cosmetic and not covered.

5. LIMITATIONS/EXCLUSIONS:

The following procedures, when performed to assist with back pain, are not considered medically necessary:

a. Abdominoplasty
b. Diastasis recti repair
c. Panniculectomy

CPT 15847 for abdominoplasty describes a cosmetic procedure, and is not covered.

6. APPLICABLE PROCEDURE CODES:

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

7. EXCLUDED PROCEDURE CODES:

CPT	Description
15847	Other excision of excessive skin and subcutaneous tissue of the abdomen.

9. APPLICABLE DIAGNOSIS CODES:

CODE	Description
E65	Localized adiposity
L98.7	Excessive and redundant skin and subcutaneous tissue (eff. 10/01/2016)
M79.3	Panniculitis, unspecified

10. REFERENCES:

American Society of Plastic Surgeons: Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. 2017. https://www.plasticsurgery.org/documents/Health-Policy/Guidelines/guideline-2017-skin-redundancy.pdf

American Society of Plastic Surgeons. Recommended Insurance Coverage Criteria. Panniculectomy. 2019. https://www.plasticsurgery.org/documents/Health-Policy/Reimbursement/insurance-2019-panniculectomy.pdf

American Society of Plastic Surgeons. Recommended Insurance Coverage Criteria. Abdominoplasty. 2018. https://www.plasticsurgery.org/documents/Health-Policy/Reimbursement/insurance-2018-abdominoplasty.pdf

Lockwood T. Rectus muscle diastasis in males: primary indication for endoscopically assisted abdominoplasty. *Plast Reconstr Surg. 1998;101:1685-1691.*

Modolin M, Cintra W Jr, Gobbi CI, Ferreira MC. Circumferential abdominoplasty for sequential treatment after morbid obesity. *Obes Surg. 2003;13:95-100.*

O'Brien JJ, Glasgow A, Lydon P. Endoscopic balloon-assisted abdominoplasty. *Plast Reconstr Surg. 1997;99:1462-1463.*

Ramirez OM. Abdominoplasty and abdominal wall rehabilitation: a comprehensive approach. *Plast Reconstr Surg. 2000;105:425-35.*

Schechner SA, Jacobs JS, O'Louhglin KC. Plastic or reconstructive body contouring of the post-vertical banded gastroplasty patient: a retrospective review. *Obes Surg.1991;1:415-417.*

Seung-Jun O, Thaller SR. Refinements in abdominoplasty. *Clin Plast Surg. 2002;29:95-109,vi.*

Specialty-matched clinical peer review.

The Safety of Pelvic Surgery in the Morbidly Obese With and Without Combined Panniculectomy: A Comparison of Results. Hardy, James E. MD; Salgado, Christopher J. MD; Matthews, Martha S. MD; Chamoun, George MD; Fahey, A Leilani MD Annals of Plastic Surgery: January 2008 - Volume 60 - Issue 1 - pp 10-13

REVISION LOG:

REVISIONS	DATE
Creation date	7/20/2017
Annual Review	10/25/19
Annual Review	10/2/20
Annual Review	9/1/21
Annual Review	7/25/2022
Annual Review	8/29/2023
Annual Review, CPT Code exclusion added	7/22/2024

Approved:	Date:	Approved:	Date:
David Ackman Digitally signed by David Ackman Date: 2024.08.14 11:03:54 -04'00'		Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2024.08.13 14:05:42 -04'00'	
David Ackman, MD **VP of Medical Director**		**Sanjiv Shah, MD** **Chief Medical Officer**	

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly

review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.