



PANNICULECTOMY AND ABDOMINOPLASTY HS-033



Harmony Behavioral Health, Inc.

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Panniculectomy and Abdominoplasty

Policy Number: HS-033

Original Effective Date: 7/17/2008

**Revised Date(s): 7/23/2009; 7/28/2010;
8/2/2011; 4/5/2012**

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

BACKGROUND

Abdominoplasty, often referred to as a "tummy tuck," is a surgical procedure that tightens lax anterior abdominal wall muscles and removes excess abdominal skin and fat. This recontouring of the abdominal wall area is often performed solely to improve the appearance of the abdomen. The standard abdominoplasty involves plication of the anterior rectus sheath for muscle diastasis (i.e., repair of diastasis recti) and removal of excess fat and skin. Traditional abdominoplasty can be performed as an open procedure or endoscopically. Abdominoplasty completed by endoscopic guidance is usually reserved for those patients who seek less extensive contouring of the abdominal wall. Mini-abdominoplasty, with or without liposuction, is a partial abdominoplasty involving the incision of the lower abdomen only. The procedure is generally performed solely for cosmetic purposes in order to improve abdominal appearance.

Panniculectomy, a procedure closely related to abdominoplasty, is the surgical removal of a redundant, large and/or long overhanging apron of skin and subcutaneous fat located in the lower abdominal area. The condition may accompany significant overstretching of the lax anterior abdominal wall and, hence, often occurs in morbidly obese individuals or following substantial weight loss. The severity of abdominal deformities is graded as follows (American Society of Plastic Surgeons, 2007):

- Grade 1: panniculus covers hairline and mons pubis but not the genitals
- Grade 2: panniculus covers genitals and upper thigh crease
- Grade 3: panniculus covers upper thigh
- Grade 4: panniculus covers mid-thigh
- Grade 5: panniculus covers knees and below

Treatment of this redundant skin and fat is often performed solely for cosmesis, to improve the appearance of the abdominal area. The presence of a massive overhanging apron of fat and skin, however, may result in chronic and persistent local skin conditions in the abdominal folds. These conditions may include intertrigo, intertriginous dermatitis, cellulitis, ulcerations or tissue necrosis, or they may lead to painful inflammation of the subcutaneous adipose tissue (i.e., panniculitis). When panniculitis is severe, it may interfere with activities of daily living, such as personal hygiene and ambulation. In addition to excellent personal hygiene practices, treatment of these skin conditions generally involves topical or systemic corticosteroids, topical antifungals, and topical or systemic antibiotics.

No correlation has been established between the presence of abdominal wall laxity or redundant pannus and the development of neck or back pain. There is insufficient evidence in the published, peer-reviewed scientific literature to support the use of abdominoplasty and/or panniculectomy to treat neck or back pain, including pain in the cervical, thoracic, lumbar or lumbosacral regions. Abdominoplasty or panniculectomy is considered not medically necessary when performed for the sole purpose of treating neck or back pain.

POSITION STATEMENT

Panniculectomy **is considered medically necessary** if ALL the following criteria are met:

1. Frontal and lateral photographs document that the panniculus hangs to or below the level of the pubis; **AND**,
2. The panniculus causes a documented chronic and persistent skin condition (e.g., rashes, infections, intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that recurs over a period of 6 months while receiving appropriate medical therapy; **AND**,
3. The panniculus interferes with activities of daily living (Interference must be properly documented in the medical record).

If panniculectomy is performed following bariatric surgery or non-surgical significant weight loss (≥ 100 pounds), in addition to meeting the criteria above, the member must meet the additional criteria listed below:

1. The member's weight must be stable for a minimum of 6 months; **AND**,
2. Eighteen months must pass after bariatric surgery before panniculectomy is performed (if weight loss is due to bariatric surgery).

Panniculectomy and abdominoplasty* **is considered experimental and investigational and NOT a covered benefit** for the following indications:

1. Treatment of neck or back pain; **OR**,
2. Improving appearance (cosmetic purposes); **OR**,
3. Repairing abdominal wall laxity or diastasis recti; **OR**,
4. Treating psychological symptomatology or psychosocial complaints; **OR**,
5. Risk minimization of hernia formation or recurrence

Note: Repair of a true incisional or ventral hernia is considered medically necessary and a covered benefit. Proper documentation describing the hernia must be provided.

* Abdominoplasty, with or without panniculectomy, **is NOT a covered benefit** under the statutes of this policy (see above).

CODING

CPT®* Codes

- 15830** Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
- 15847** Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
- 49560** Repair initial incisional or ventral hernia, reducible
- 49561** Repair initial incisional or ventral hernia; incarcerated or strangulated
- 49565** Repair recurrent incisional or ventral hernia; reducible
- 49566** Repair recurrent incisional or ventral hernia; incarcerated or strangulated
- 49568+** Implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection.
+(List Separately in addition to code for the incisional or ventral hernia repair.)

Note: Repair of a true incisional or ventral hernia **is considered medically necessary and a covered benefit**. Proper documentation describing the hernia must be provided.

ICD-9 Procedure Codes

- 86.83** Abdominoplasty / Panniculectomy
- 53.51** Ventral Incisional Hernia repair
- 53.59** Ventral Hernia repair
- 53.61** Ventral Incisional Hernia repair with prosthesis or graft (Mesh)

HCPCS Codes - No applicable codes

ICD-9-CM Diagnosis Codes

278.1	Localized adiposity [panniculus adiposus] [documentation required]
551.20 - 551.29	Ventral hernia with gangrene
552.20 - 552.29	Ventral hernia with obstruction
553.20 - 553.29	Ventral hernia, unspecified
682.2	Other cellulitis and abscess, trunk
692.9	Contact dermatitis and other eczema, unspecified cause
695.89	Other specified erythematous conditions, other
701.8	Other specified hypertrophic and atrophic conditions of skin
701.9	Unspecified hypertrophic and atrophic conditions of skin
707.8	Chronic ulcer of other specified site
707.9	Chronic ulcer of unspecified site
729.30	Panniculitis, unspecified site
729.39	Panniculitis of other sites
V45.86	Bariatric Surgery Status

Non Covered CPT* Codes

15877 Suction assisted lipectomy; trunk

Non Covered ICD-9-CM Procedure Codes

86.83 Lipectomy

HCPCS Codes - No applicable codes

Non Covered ICD-9-CM Diagnosis Codes

723.1	Cervicalgia
723.6	Panniculitis specified as affecting neck
724.2	Lumbago
724.5	Backache, unspecified
728.84	Diastasis of muscle

*Current Procedural Terminology (CPT) 2012 American Medical Association: Chicago, IL.®©

REFERENCES

Peer Reviewed

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HISTORY AND REVISIONS

Date	Action
4/5/2012	<ul style="list-style-type: none">• Approved by MPC. Added new Hayes reference. No changes.
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
8/2/2011	<ul style="list-style-type: none">• Approved by MPC. No changes.