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.
PANNICULECTOMY AND ABDOMINOLAPSTY
HS-033

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. Note: The lines of business (LOB) are subject to change without notice; consult www.wellcare.com/Providers/CCGs for list of current LOBs.

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

Applicable To:
- Medicaid – All Markets
- Medicare – All Markets
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.

**CODING**

**Covered CPT® Codes**

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)

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 part of a standard abdominoplasty. When a true hernia repair is performed, the following distinct codes, separate from the abdominoplasty/panniculectomy, may be utilized.

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.
Non Covered CPT* Codes
15877  Suction assisted lipectomy; trunk

HCPCS Codes - No applicable code.

Covered 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)

Non Covered ICD-9-CM Procedure Code
86.83  Lipectomy

Covered 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 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

Covered DRAFT ICD-10-PCS Codes
0J080ZZ  Alteration of Abdomen Subcutaneous Tissue and Fascia, Open Approach
0J083ZZ  Alteration of Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0WQF0ZZ, 0WQF3ZZ, 0WQF4ZZ  Repair Abdominal Wall
0WUF07Z, 0WUF0JZ, 0WUF0KZ  Supplement Abdominal Wall with Autologous Tissue Substitute

Covered ICD-10-Diagnosis Codes
E65  Localized adiposity
K43.00 - K43.09  Ventral hernia with obstruction, without gangrene
K43.10 - K43.19  Ventral hernia with gangrene
K43.90 - K43.99  Ventral Hernia without obstruction or gangrene
L03.311  Cellulitis of abdominal wall
L03.319  Cellulitis of trunk, unspecified
L25.9  Unspecified contact dermatitis, unspecified cause
L53.8  Other specified erythematous conditions
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L91.8 Other hypertrophic disorders of the skin
L91.9 Hypertrophic disorder of the skin, unspecified
L98.491 - L98.499 Non-pressure chronic ulcer of skin of other sites
M79.3 Panniculitis, unspecified
Z98.84 Bariatric surgery status

Non Covered ICD10-CM Diagnosis Codes
M54.02 Panniculitis affecting regions of the neck and back, cervical region
M54.2 Cervicalgia
M54.5 Low back pain
M54.89 Other dorsalgia
M54.9 Dorsalgia, unspecified
M62.00 Separation of muscle (nontraumatic)

Non-Covered Draft ICD-10-CM Diagnosis Codes
0J080ZZ Alteration of Abdomen Subcutaneous Tissue and Fascia, Open Approach
0J083ZZ Alteration of Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach

REFERENCES

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<td>7/11/2015</td>
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<tr>
<td>8/7/2014</td>
<td>Approved by MPC. Added coding language regarding hernia repair.</td>
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<td>1/9/2014</td>
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<td>12/6/2012</td>
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<td>4/5/2012</td>
<td>Approved by MPC. Added new Hayes reference. No changes.</td>
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<td>12/1/2011</td>
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<td>8/2/2011</td>
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