SCOPE:

This policy addresses medically necessary and cosmetic reconstructive surgery related to weight loss. For coverage criteria for panniculectomy in absence of weight loss, see CMS03.12 Cosmetic and Reconstructive Surgery.

POLICY:

For US Family Health Plan see TRICARE Policy Manual 6010.57-M, February 1, 2008, Cosmetic, Reconstructive, and Plastic Surgery – General Guidelines: Chapter 4, Section 2.1 and Surgery for Morbid Obesity: Chapter 4, Section 13.2.

For Advantage MD, see Medicare Coverage Database:
See Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery (L35090)

Cross reference with Medical Policies:

- CMS02.02 Bariatric Surgery
- CMS03.12 Cosmetic and Reconstructive Services

I. When benefits are provided under the member’s contract, JHHC considers panniculectomy medically necessary when ALL of the following criteria are met:
   A. The patient is \( \geq 18 \) years of age, AND;
   B. The panniculus is Grade 2 (panniculus covers the genitals and upper thigh crease) or higher, AND;
   C. There is documentation in the Primary Care Provider’s medical record of EITHER:
1. A significant functional deficit, such as impaired ambulation, directly related to the panniculus, OR;
2. Significant interference with the activities of daily living directly related to the panniculus, AND;
D. There is documentation in the Primary Care Provider’s medical record and in the pharmacy claims dated prior to consultation with the Surgeon demonstrating chronic, unremitting intertrigo and ALL of the following:
   1. Education regarding and compliance with standard preventive skin care strategies, AND;
   2. Compliance with and lack of response to standard topical and systemic therapy for a minimum of three (3) months, AND;
E. BMI is <30, OR ≥ 100 lb. weight loss, OR ≥ 40% of excess weight loss, AND;
F. Medical records document a stable weight for a minimum of six (6) consecutive months prior to consultation with the Surgeon, AND;
G. Any nutritional deficiencies and/or endocrinopathies have been adequately treated, AND;
H. For those patients whose weight loss is secondary to bariatric surgery, a minimum of 18 months has elapsed from the date of the bariatric surgery.

II. Unless specific benefits are provided under the member’s contract, JHHC considers panniculectomy experimental and investigational for all other indications, as it does not meet Technology Evaluation Criteria (TEC) #2-5.

III. Unless specific benefits are provided under the member’s contract, JHHC considers the following procedures cosmetic:
A. Abdominoplasty
B. Liposuction
C. Thigh and buttock lift
D. Brachioplasty
E. Mastopexy
F. Face and neck lift
G. Chest and back contouring
H. Repeat panniculectomy

BACKGROUND:
Availability of bariatric surgery as well as other weight loss programs has resulted in significant weight loss for many morbidly obese patients. The health benefits of weight loss to these patients are obvious, but they are often left with unwanted skin and fat folds. By definition of the American Society of Plastic Surgeons, reconstructive surgery or body contouring refers to the removal of excess/sagging skin and fat.
Following bariatric surgery and other life-changing procedures that cause massive weight loss, patients are often left with excess skin that can cause psychological complications and anatomic deformities. Excess skin can cause rashes and make it difficult for patients to adequately cleanse their bodies (Cabbabe, 2016). Fungal infections are also common side effects following severe weight loss. Several studies have highlighted the benefits of removing excess skin following dramatic weight losses in order to address the issues previously described (Tremp, 2015).

When surgery to remove excessive skin and fat folds is performed solely to enhance a patient's appearance in the absence of any signs or symptoms of functional abnormalities, the procedure is considered cosmetic and not approved.

**CODING INFORMATION:**

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage and referral requirements. All inpatient admissions require pre-authorization.

**PRE-AUTHORIZATION REQUIRED**

*Compliance with the provision in this policy may be monitored and addressed through post-payment data analysis and/or medical review audits*

<table>
<thead>
<tr>
<th>Employer Health Programs (EHP) <strong>See Specific Summary Plan Description (SPD)</strong></th>
<th>Priority Partners (PPMCO) refer to COMAR guidelines and PPMCO SPD then apply policy criteria</th>
<th>US Family Health Plan (USFHP), TRICARE Medical Policy supersedes JHHC Medical Policy. If there is no Policy in TRICARE, apply the Medical Policy Criteria</th>
<th>Advantage MD, LCD and NCD Medical Policy supersedes JHHC Medical Policy. If there is no LCD or NCD, apply the Medical Policy Criteria</th>
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<td>CPT @ CODE</td>
<td>DESCRIPTION</td>
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<tr>
<td>15830</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy</td>
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NOT COVERED FOR THIS INDICATION

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<tr>
<td>15828</td>
<td>Rhytidectomy; cheek, chin, and neck</td>
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<tr>
<td>15829</td>
<td>Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap</td>
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<tr>
<td>15832</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</td>
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<td>15835</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttck</td>
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<td>15836</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm</td>
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<tr>
<td>15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</td>
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</table>
| 15847 | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen
eg(abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in
to code for primary procedure) |
| 15876 | Suction assisted lipectomy; head and neck                                   |
| 15877 | Suction assisted lipectomy; trunk                                           |
| 15878 | Suction assisted lipectomy; upper extremity                                |
| 15879 | Suction assisted lipectomy; lower extremity                                 |
| 19316 | Mastopexy                                                                   |

ICD10 CODES ARE FOR INFORMATIONAL PURPOSES ONLY

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<th>ICD10 CODES</th>
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<td>M79.3</td>
<td>Panniculitis, unspecified</td>
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<td>Z68.20-Z68.29</td>
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Revenue Codes

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<tr>
<td>0361</td>
<td>Operating Room Services-Minor Surgery; Hospital; outpatient</td>
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REFERENCE STATEMENT:

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins HealthCare LLC (JHHC) Medical Policy Team during the development and implementation of this medical policy. Per NCQA standards, the Medical Policy Team will continue to monitor and review any newly published clinical evidence and adjust the references below accordingly if deemed necessary.
REFERENCES:


COMAR. Pre-authorization Requirements: Cosmetic Surgery. Retrieved: http://www.dsd.state.md.us


