Description of Procedure or Service

Panniculectomy is a surgical procedure used to remove a panniculus, which is an “apron” of fat and skin that hangs from the front of the abdomen.

Abdominoplasty, known more commonly as a "tummy tuck," is a surgical procedure to remove excess skin and fat from the middle and lower abdomen and to tighten the muscles of the abdominal wall.

Liposuction, also known as lipoplasty or suction-assisted lipectomy, is a surgical procedure performed to recontour the patient's body by removing excess fat deposits that have been resistant to reduction by diet or exercise.

Policy Statement

GEHA will provide coverage for panniculectomy when it is determined to be medically necessary because the medical criteria and guidelines as documented below have been demonstrated.

Benefit Application

Non-covered benefits include cosmetic surgery, defined as any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated promptly or as soon as the member’s condition permits.

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits.

When Panniculectomy is covered

GEHA considers panniculectomy medically necessary when all of the following conditions are met:

A. Pannicus hangs below level of pubis Grade 2 or higher (see policy guidelines), documented by photographs.
   The pannus causes a chronic and persistent skin condition (e.g., intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least three months of medical treatment and associated with at least one episode of cellulitis requiring systemic antibiotics. In addition to good hygiene practices, documented treatment should typically include topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics.

B. Photographs with pannus lifted are provided that clearly document presence of intertrigo following standard therapy. Evidence of significant weight loss, typically defined as at least 100lbs. If the weight loss is secondary to performance of bariatric surgery, additional criteria must also be met including:
1. significant weight loss down to a BMI of <= 30 kg/m² and
2. weight stability for 6 months and
3. A waiting period of 18 months following bariatric surgery before a panniculectomy can be undertaken. (If performed prematurely, there is the potential for a second panniculus to develop once additional weight loss has occurred) (Hayes, 2016).

When Abdominoplasty/Panniculectomy/Lipectomy is not covered

- Concurrent use of panniculectomy for either gynecological or abdominal procedures to facilitate the primary procedure, such as ventral hernia repair healing.
- Panniculectomy for minimizing the risk of hernia formation or recurrence. There is inadequate evidence that pannus contributes to hernia formation. The primary cause of hernia formation is an abdominal wall defect or weakness, not a pulling effect from a large or redundant pannus.
- Panniculectomy for the treatment of back pain, with and/or without the presence of diastasis recti is considered investigational.
- Surgical procedures to correct diastasis recti have not been demonstrated to be effective for alleviating back pain or other non-cosmetic conditions. At this time, there is insufficient evidence to support the use of surgical procedures to correct diastasis recti for other than cosmetic purposes.
- Abdominoplasty is considered cosmetic and not medically necessary when not associated with functional improvements.
- Liposuction, including suction-assisted or ultrasound-assisted lipectomy, is considered cosmetic and not medically necessary for all body areas when not associated with functional improvements.
- There is inadequate evidence to support the use of Lipectomy/liposuction for the purpose of treating lymphedema.
- Panniculectomy or lipoabdominoplasty for the management of metabolic syndrome or as an adjunct to weight loss for bariatric intervention is considered investigational.
- GEHA considers adipose derived stem cell-assisted lipotransfer experimental and investigational because there is insufficient evidence to demonstrate effectiveness.

Policy Guidelines

Panniculectomy is intended for patients with massive weight loss who are left with a large panniculus that causes serious medical conditions that are unresponsive to or are requiring frequent medical treatment, and that are having a negative effect on quality of life (Hayes, 2015).

The severity of abdominal deformities is graded as follows (American Society of Plastic Surgeons [ASPS], 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

**Physician Documentation**

For adequate review of any requests for the above noted procedures, a surgical request must be submitted, utilizing the GEHA Authorization form, and including all of the following:

- Medical records that demonstrate the current surgical indication and document relevant clinical findings.
- Detail of the requested procedure including specified surgical codes and/or products anticipated.
- Legible color photographic evidence demonstrating clinical findings as noted above.
- If the member has a history of prior bariatric surgery, then relevant history including the procedure(s) performed, timing of prior procedure(s), documentation of surgical follow-up and weight trends, etc.
- A completed GEHA Panniculectomy/Abdominoplasty form. This form is available within the provider documents section at GEHA.com.

The documentation of medical treatment should typically be from a physician other than the surgeon. Documentation from a dermatologist or infectious disease specialist is highly preferable. Documentation should be in the form of physician office notes over a three month period rather than a summary treatment letter.

**Background**

**Panniculectomy**

Panniculectomy is generally considered when the patient experiences reoccurring skin issues that adversely affect daily activities. In certain circumstances, this “apron” can be associated with skin irritation and infection due to interference with proper hygiene and constant skin-on-skin contact in the folds underneath the panniculus. The presence of a panniculus may also interfere with daily activities. Panniculectomy in obese patients is usually performed in a hospital due to the medical status of these patients and the extensive nature of the surgery. Patients may be hospitalized for one or two weeks or more, and complete wound healing may take several months.

**Abdominoplasty**

Abdominoplasty can improve cosmesis by reducing the protrusion of the abdomen. The first step involves creating a surgical incision across the abdomen followed by separation of the muscles from the layer of skin and fat over it. The muscles are then separated along the mid-line of the belly and brought together again in a new configuration. The layer of skin and fat is then pulled downward and the excess is removed. The navel is often re-positioned during this surgery. Abdominoplasty is considered cosmetic because it is not associated with functional improvements (National Library of Medicine, n.d.)
Diastasis recti

Abdominoplasty may also be used to correct a condition known as diastasis recti, which is a separation between the left and right side of the rectus abdominis muscle, the muscle covering the front surface of the abdomen. This condition is frequently seen in newborns. As the infant develops, the rectus abdominis muscles continue to grow and the diastasis recti gradually disappears. Surgical treatment may be indicated if a hernia develops and becomes trapped in the space between the muscles, although this is extremely rare. Diastasis recti may also be seen in some women during or following pregnancy, especially in women with poor abdominal tone. The abdominal muscles separate because of the increasing pressure of the growing fetus. In such cases, postpartum abdominal exercises to strengthen the musculature may close the diastasis recti (National Library of Medicine, n.d.) (Thorne, 2014).

Ventral hernia

In order to distinguish a ventral hernia repair from a diastasis recti, documentation of the size of the hernia, whether the ventral hernia is reducible, whether the hernia is accompanied by pain or other symptoms, the extent of diastasis (separation) of rectus abdominus muscles, whether there is a defect (as opposed to mere thinning) of the abdominal fascia, and office notes indicating the presence and size of the fascial defect may be required.

Concurrent panniculectomy surgeries

Fischer et. al. (2014) assessed the risks and benefits of performing concurrent panniculectomy (PAN) in the setting of hernia repair, gynecologic surgery, and oncologic resections with conflicting results. The aim of this study was to assess the added risk of ventral hernia repair and panniculectomy (VHR-PAN) using the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) data sets. A total of 55,537 patients were identified. Propensity matching yielded two groups of patients: VHR (n = 1250) and VHR-PAN (n = 1250). Few statistically significant differences existed between matched cohorts. Overall, wound complications (P < 0.001), venous thromboembolism (P = 0.044), incidence of reoperation (P < 0.001), and medical morbidity (P < 0.001) were significantly higher in the VHR-PAN group. In an adjusted, fixed-effects analysis, concurrent panniculectomy was associated with wound healing complications (OR = 1.69, P < 0.001), increased incidence of unplanned reoperations (OR = 2.08, P < 0.001), venous thromboembolism (OR = 2.48, P = 0.043), and overall medical morbidity (OR = 2.08, P < 0.001). Sub-group analysis of wound complications demonstrated that superficial surgical site infections occurred significantly more often in concurrent cases (P = 0.018). This analysis quantifies the added risk of performing a panniculectomy concurrent with ventral hernia repair, demonstrating higher incidence of wound complications (superficial infections), unplanned reoperations, and VTE.

Another study examining nationwide data was conducted to determine how open ventral hernia repair techniques in complex abdominal wall reconstruction impacts postoperative complications. The National Surgical Quality Improvement Program database was queried from 2005 to 2013 for inpatient, elective open ventral hernia repairs (OVHR). Cases were grouped by the need for and type of concomitant advancement flaps: OVHR alone (OVHRA), OVHR with CS, OVHR with panniculectomy (PAN), or both CS and PAN (BOTH). Multivariate regression to control for confounding factors was conducted. There were 58,845 OVHR: 51,494 OVHRA, 5,357 CS, 1,617 PAN, and 377 BOTH. Wound complications (OVHRA 8.2%, CS 12.8%, PAN 14.4%, BOTH 17.5%), general complications (15.2%, 24.9%, 25.2%, 31.6%), and major complications (6.9%, 11.4%, 7.2%, 13.5%) were different between groups (P <
There was no difference in mortality. Multivariate regression showed CS had higher odds of wound [odds ratio (OR) 1.7, 95% confidence interval (CI) 1.5-2.0], general (OR 1.5, 95% CI: 1.3-1.8), and major complications (OR 2.1, 95%, CI: 1.8-2.4), and longer length of stay by 2.3 days. PAN had higher odds of wound (OR 1.5, 95%, CI: 1.3-1.8) and general complications (OR 2.5, 95%, CI: 1.8-3.4), and major complications (OR 2.2, 95%CI: 1.4-3.4), and two days longer length of stay. In conclusion, patients undergoing OVHR that require CS or PAN have a higher independent risk of complications, which increases when the procedures are combined (Ross et. al., 2015).

**Lipectomy/Liposuction**

Suction-assisted liposuction (SAL) is a method of removing unwanted fatty deposits from specific areas of the face and body. The surgeon makes a small incision and inserts a cannula attached to a vacuum device that suctions out the fat. Suction-assisted liposuction is not an alternative to weight loss. It is intended for use on localized areas of fat that do not respond to diet or exercise. Areas suitable for liposuction include the chin, neck, cheeks, upper arms, area above the breasts, the abdomen, flanks, the buttocks, hips, thighs, knees, calves and ankles. Liposuction can improve body contour and provide a sleeker appearance. Surgeons may also use liposuction to remove lipomas (benign fatty tumors) in some cases.

Ultrasound-assisted liposuction (UAL) is a relatively new liposuction technique in the United States. It is similar to traditional liposuction procedures. However, UAL uses ultrasonography to target and remove fatty tissues more selectively and with minimal impact on surrounding tissues and blood vessels. Ultrasonic energy is used to fractionate or burst the fat cells. The fat is then removed with relatively low-volume suction, resulting in less trauma to tissues. Incisions, however, are larger.

Seretis et. al. (2015) performed a systematic review and meta-analysis to examine the effects of abdominal lipectomy in metabolic syndrome components and insulin sensitivity in females. The systematic review included 11 studies with a total of 271 individuals. Conflicting results were revealed, though most studies showed no significant metabolic effects after lipectomy. The meta-analysis included 4 studies with 140 subjects. No significant changes were revealed between lipectomy and control groups. This meta-analysis provides evidence that abdominal lipectomy in females does not affect significantly the components of metabolic syndrome and insulin sensitivity. Further high quality studies are needed to elucidate the potential metabolic effects of abdominal lipectomy.

**Regulatory Status**

Abdominoplasty, Panculectomy, and Lipectomy are procedures and, as such, are not subject to regulation by the FDA.

However, the FDA does regulate manufacturing practices and use of devices and drugs for such procedures. These include but are not limited to surgical mesh that is often used in abdominal wall procedures.

**The following codes are for reference purposes only and do not imply that the service is covered or non-covered. Applicable codes include but are not limited to:**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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Origination Date: Dec 2016  Peer Reviewed: Dec 2019  Next Review Date: Dec 2020
Abdominoplasty
Considered cosmetic/not medically necessary

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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>15847</td>
<td>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)</td>
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<tr>
<td>17999</td>
<td>Unlisted procedure, skin, mucous membrane and subcutaneous tissue</td>
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Suction Assisted Lipectomy
Considered cosmetic/not medically necessary when performed alone and not part of a medically necessary panniculectomy

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<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
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Scientific References


Policy implementation and updates

12/2017 Policy name changed from Abdominoplasty/Panniculectomy/Ventral Hernia Repair. Additional clarity regarding lipectomy for other body areas added. Clarification of necessity criteria for coverage of panniculectomy.

12/2018 Clarification, Review, and reformatting of content.

12/2019 Background content added with reference update. No change in policy coverage.