Medical Review Criteria:

Panniculectomy/Removal of Redundant Tissue

Effective Date: 7/2010

Subject: Panniculectomy/Removal of Redundant Skin and Subcutaneous Tissue

Policy:
HPHC covers panniculectomy (surgical removal of the pannus, a hanging "apron" of excess abdominal skin left behind after massive weight loss) and/or the removal of excess/redundant skin and subcutaneous tissue from other areas, when the procedure is reasonable and medically necessary to improve or correct a physical functional impairment or medical complication that occurred after weight loss.

- A physical functional impairment is a condition in which the normal/proper action of a body part is damaged or diminished, and adversely affects the individual’s ability to participate in normal activities of daily life (e.g., walking, sleeping, eating, toileting).
- The pannus or excess/redundant skin's impact on the individual’s emotional well-being or mental health is not considered in determining if a physical functional impairment exists.

In the absence of a physical functional impairment or medical complication, HPHC does not cover panniculectomy or the removal of excess/redundant skin requested for cosmetic reasons (i.e., to reshape or improve the patient’s appearance)\(^1\), or to treat psychological or psychosocial issues related to redundant skin.

Liposuction (CPT codes 15830-15839) that is an integral part of covered services such as the surgical removal of excessive skin, is NOT separately reimbursed.

Authorization:
Prior authorization is required for ALL the following:
- Panniculectomy
- Removal of Redundant Skin and Subcutaneous Tissue

Please see HPHC's Breast Surgeries Medical Review Criteria or HPHC Gynecomastia Medical Review Criteria for criteria related to removal of excess/redundant breast skin/tissue.

General Criteria:
Panniculectomy and/or the removal of redundant skin and subcutaneous tissue from anatomical areas other than the abdomen is authorized when documentation confirms ALL the following:
1. Member has achieved weight loss of at least 75 lbs.; AND
2. The member is experiencing a physical functional impairment or significant skin complication; AND
3. The requested procedure can reasonably be expected to restore functionality and/or resolve associated medical complications; AND
4. EITHER of the following:

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\(^1\) HPHC excludes coverage for most cosmetic procedures that are not specifically listed as covered services in the member's Handbook or Evidence of Coverage (EOC).

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HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members’ unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.
- Weight loss occurred following lifestyle changes (including diet and exercise) or medical intervention, and member’s weight has been stable for at least 6 months; OR
- Weight loss occurred following bariatric surgery, and member’s weight has been stable for at least 12 months post surgery.

5. Procedure-specific criteria (below) are met.

### Procedure-Specific Criteria:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Criteria</th>
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</table>
| **Panniculectomy**                              | Frontal and lateral photographs (taken when the patient is standing erect) are required, and must demonstrate the degree of the pannus and any related skin conditions.*  
  Authorized when documentation confirms ALL the following:  
  1. Weight loss has resulted in an occlusive overhanging pannus that covers the genitals and upper thigh crease, upper or mid-thigh, or knees and below (Grade 2 or higher on ASPS scale²); AND  
  2. The pannus directly causes ANY of the following:  
     - A physical functional impairment that interferes with activities of daily living including physical exercise;  
     - Persistent symptomatic intertriginous ulcerations or macerations that have been refractory to good personal hygiene and several months of physician-supervised local treatment.  
     - Documentation must include a detailed description of all physician-supervised skin treatment.  
     - Recurrent skin infections (i.e., at least 2 episodes within 12 months) that required systemic antibiotics, and are directly related to the pannus. |
| **Removal of Redundant Skin and Subcutaneous Tissue from Anatomical Areas Other Than Breast or Abdomen** | Removal of redundant skin (e.g., from thighs, hips, buttocks, and/or arms) is authorized when documentation confirms ALL the following:  
  1. Weight loss has resulted in significant excess/redundant skin or skin folds; AND  
  2. Redundant skin and/or skin folds directly cause ANY of the following:  
     - A physical functional impairment that interferes with activities of daily living including physical exercise.  
     - Persistent symptomatic intertriginous ulcerations or macerations that have been refractory to good personal hygiene and physician-supervised local treatment over a period of several months.  
     - Documentation must include a detailed description of all physician-supervised skin treatment.  
     - Recurrent skin infections (i.e., at least 2 episodes within 12 months) that required systemic antibiotics, and are directly related to the pannus. |

² The severity of abdominal deformities is graded as follows (American Society of Plastic Surgeons [ASPS], 2007d):  
- Grade 1: pannus covers hairline and mons pubis but not the genitals  
- Grade 2: pannus covers genitals and upper thigh crease  
- Grade 3: pannus covers upper thigh  
- Grade 4: pannus covers mid-thigh  
- Grade 5: pannus covers knees and below
* Photo documentation must be mailed or emailed to HPHC as faxed photos cannot be utilized in making a determination of medical necessity.

Coding: Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>15830</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy</td>
</tr>
<tr>
<td>15832</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</td>
</tr>
<tr>
<td>15833</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg</td>
</tr>
<tr>
<td>15834</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip</td>
</tr>
<tr>
<td>15835</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock</td>
</tr>
<tr>
<td>15836</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm</td>
</tr>
<tr>
<td>15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</td>
</tr>
<tr>
<td>15847</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial placation) List separately in addition to code for primary procedure</td>
</tr>
<tr>
<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
</tr>
<tr>
<td>15878</td>
<td>Suction assisted lipectomy; upper extremity</td>
</tr>
<tr>
<td>15879</td>
<td>Suction assisted lipectomy; lower extremity</td>
</tr>
</tbody>
</table>

Exclusions:
HPHC does not authorize Panniculectomy or removal of excess/redundant skin when criteria above are not met.

In addition, HPHC does not authorize:
- Abdominoplasty
- Diastasis recti repair
- Panniculectomy or removal of excess/redundant skin for treatment of psychological or psychosocial issues related to redundant skin
- Panniculectomy or removal of excess/redundant skin performed at the time of an additional abdominal or gynecological surgery unless criteria above are met
- Suction lipectomy except as described above
- Surgical removal of redundant skin, or body contouring for cosmetic purposes only

Approved by UMCPC: 5/10/17
- Revised: 5/11, 5/12, 2/13, 3/14; 4/15; 4/16; 5/17
- Initiated: 7/1/10

Summary of Changes:

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>5/17</td>
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<tbody>
<tr>
<td>April 2016</td>
<td>Minor formatting edits.</td>
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<tr>
<td>April 2015</td>
<td>• Provide simplified description of panniculectomy procedure.</td>
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<tr>
<td></td>
<td>• Add links to public (member and provider) sites.</td>
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<td></td>
<td>• Simplify description of weight loss expectations (member’s weight must be stable for at least 6 months following lifestyle changes or medical intervention, or for at least 12 months following bariatric surgery).</td>
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<td></td>
<td>• Provide simplified description of when occlusive overhanging pannus meets criteria (kept footnote re: ASPS Grading).</td>
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<td>• Add coding profile.</td>
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<td>• Expand Exclusions to include procedures performed at the time of an additional abdominal or gynecological surgery unless criteria are met, and surgical removal of redundant skin, or body contouring for cosmetic purposes only.</td>
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<tr>
<td></td>
<td>• Add reference.</td>
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</tbody>
</table>

**References:**

- ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients