Abdominoplasty & Panniculectomy

Origination: 09/27/07	**Revised:** 7/22/20	**Annual Review:** 12/08/22

Purpose:

To provide Abdominoplasty and Panniculectomy guidelines for Population Health and Provider Alliances associates to reference when making determinations.

Coverage Guidelines

Panniculectomy could be considered medically indicated if all of the following criteria are met and reviewed by a Medical Director:

- Panniculus hangs below the level of the pubis as evidenced by photo documentation.
- There is medical record documentation that the panniculus causes chronic intertrigo/dermatitis or ulcerations that consistently recur over three (3) months while being treated with appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of three (3) months;
- If criteria are met, covered procedure codes include 15830, 49560, 49561, 49565, 49566, 49568.

Exclusion Criteria

- Panniculectomy is considered cosmetic when performed for reasons to "minimize the risk" of hernia formation or recurrence:

  ❖ There is no adequate 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.

- Repair of a Diastasis Recti is not considered to be medically necessary. According to medical literature, it is not a true hernia and is of no clinical significance.

- Abdominoplasty and Suction Lipectomy are considered cosmetic.

- Non-covered procedure codes include 15847 and 15877.

References:

1. Guiding principles for liposuction. The American Society for Dermatologic Surgery, February 1997. Dermatol Surg. 1997;23(12):1127-1129.

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3. Larson GM. Laparoscopic repair of ventral hernia. In: SAGES Primary Care Physicians Resource Center. Santa Monica, CA: Society of American Gastrointestinal Endoscopic Surgeons (SAGES); 2001.

4. Review from Hayes Health Technology. Tumescent Liposuction. February 2001.

5. Aly AS, Cram AE, Chao M, et al. Belt lipectomy for circumferential truncal excess: The University of Iowa experience. Plast Reconstr Surg. 2003;111(1):398-413.

6. State of Minnesota, Health Technology Advisory Committee. Tumescent liposuction. St. Paul, MN: HTAC; 2002.

7. Cooter R, Robinson D, Babidge W, et al. Systematic review of ultrasound-assisted lipoplasty: Update and reappraisal. North Adelaide, Australia: Royal Australasian College of Surgeons, Australian Safety and Efficacy Register of New Interventional Procedures (ASERNIP) - Surgical; 2002.

8. Sanchez LJ, Bencini L, Moretti R. Recurrences after laparoscopic ventral hernia repair: Results and critical review. Hernia. 2004;8(2):138-143.

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Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.