Anthem

Clinical UM Guideline

Subject: Panniculectomy and Abdominoplasty
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Description

This document addresses the surgical procedures panniculectomy and abdominoplasty and when they are considered medically necessary, not medically necessary, and cosmetic.

Medically Necessary: In this document, procedures are considered medically necessary if there is a significant functional impairment AND the procedure can be reasonably expected to improve the functional impairment.

Cosmetic: In this document, procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those that are primarily intended to preserve or improve appearance.

Clinical Indications

Medically Necessary:

A. Panniculectomy is considered **medically necessary** for the individual who meets the following criteria:
   1. The panniculus hangs below the level of the pubis (which is documented in photographs);**and**
   2. **One** of the following:
      a. there are documented recurrent or chronic rashes, infections, cellulitis, or non-healing ulcers, that do not respond to conventional treatment (for example, dressing changes; topical, oral or systemic antibiotics, corticosteroids or antifungals) for a period of 3 months; **or**
      b. there is documented difficulty with ambulation and interference with the activities of daily living; **and**
   3. Symptoms or functional impairment persists despite significant* weight loss which has been stable for at least 3 months or well-documented attempts at weight loss (medically supervised diet or bariatric surgery) have been unsuccessful; **and**
   4. If the individual has had bariatric surgery, he/she is at least 18 months post-operative or has documented stable weight for at least 3 months.
   *Significant weight loss varies based on the individual clinical circumstances and may be documented when the individual:
      a. Reaches a body mass index (BMI) less than or equal to 30 kg/m^2; **or**
      b. Has documented at least a 100 pound weight loss;**or**
      c. Has achieved a weight loss which is 40% or greater of the excess body weight that was present prior to the individual's weight loss program or surgical intervention.

B. Panniculectomy is considered **medically necessary** as an adjunct to a medically necessary surgery when needed for exposure in extraordinary circumstances.

Not Medically Necessary:

A. Panniculectomy is considered **not medically necessary** when the criteria above are not met.
B. Panniculectomy is considered **not medically necessary** as an adjunct to other medically necessary procedures, including, but not limited to, hysterectomy, or incisional or ventral hernia repair unless the criteria above are met.
C. Panniculectomy or abdominoplasty, with or without diastasis recti repair, for the treatment of back pain is considered**not medically necessary.**

Cosmetic and Not Medically Necessary:

A. Liposuction is considered **cosmetic and not medically necessary** when used for the removal of excess abdominal fat.
B. Abdominoplasty when done to remove excess skin or fat with or without tightening of the underlying muscles is considered **cosmetic and not medically necessary.**
C. Repair of diastasis recti is considered **cosmetic and not medically necessary**.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Panniculectomy
When services may be Medically Necessary when criteria are met:

CPT

15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy

ICD-10 Procedure

	For the following codes when described as panniculectomy:
0HB7XZZ	Excision of abdomen skin, external approach
0J080ZZ	Alteration of abdomen subcutaneous tissue and fascia, open approach

0WBF0ZZ	Excision of abdominal wall, open approach

ICD-10 Diagnosis

All diagnoses

When services are Not Medically Necessary:
For the procedure codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

Abdominoplasty, liposuction
When services are Not Medically Necessary or Cosmetic and Not Medically Necessary:
For the following procedure codes, or when the code describes a procedure designated in the Clinical Indications section as not medically necessary or cosmetic and not medically necessary.

CPT

15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk [when specified as abdominal liposuction]
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue [when specified as other abdominoplasty, excision excessive skin and subcutaneous tissue, including lipectomy, of abdomen]

ICD-10 Procedure

0J080ZZ	Alteration of abdomen subcutaneous tissue and fascia, open approach [when specified as other abdominoplasty, excision excessive skin and subcutaneous tissue, including lipectomy]
0J083ZZ	Alteration of abdomen subcutaneous tissue and fascia, percutaneous approach
0W0F07Z-0W0F0ZZ	Alteration of abdominal wall with/without tissue substitute, open approach [includes codes 0W0F07Z, 0W0F0JZ, 0W0F0KZ, 0W0F0ZZ]
0W0F37Z-0W0F3ZZ	Alteration of abdominal wall with/without tissue substitute, percutaneous approach [includes codes 0W0F37Z, 0W0F3JZ, 0W0F3KZ, 0W0F3ZZ]
0W0F47Z-0W0F4ZZ	Alteration of abdominal wall with/without tissue substitute, percutaneous endoscopic approach [includes codes 0W0F47Z, 0W0F4JZ, 0W0F4KZ, 0W0F4ZZ]

ICD-10 Diagnosis

All diagnoses

Repair of diastasis recti
When services are Not Medically Necessary or Cosmetic and Not Medically Necessary:
For the following procedure codes, or when the code describes a procedure designated in the Clinical Indications section as not medically necessary or cosmetic and not medically necessary.

CPT

22999	Unlisted procedure, abdomen, musculoskeletal system [when specified as repair of diastasis recti]

ICD-10 Procedure

0KQK0ZZ-0KQK4ZZ	Repair right abdomen muscle [by approach; includes codes 0KQK0ZZ, 0KQK3ZZ, 0KQK4ZZ]
0KQL0ZZ-0KQL4ZZ	Repair left abdomen muscle [by approach; includes codes 0KQL0ZZ, 0KQL3ZZ, 0KQL4ZZ]

ICD-10 Diagnosis

	For the following diagnoses when specified as diastasis recti:
M62.00	Separation of muscle (nontraumatic), unspecified site
M62.08	Separation of muscle (nontraumatic), other site
O71.89	Other specified obstetric trauma
Q79.59	Other congenital malformations of abdominal wall

Discussion/General Information

Panniculectomy

The current medical evidence regarding panniculectomy consists mostly of individual case reports, review articles and a limited number of controlled trials. However, there is adequate clinical opinion to support the use of this procedure in some circumstances where an individual's health is compromised.

Early studies by Matory (1994) and Vastine (1999) demonstrated a direct relationship between BMI and operative risk with abdominal surgery and abdominoplasty in obese individuals. In a retrospective cohort series of individuals who underwent post-bariatric panniculectomy (n=126), the only factor that independently predicted postoperative complications after panniculectomy was pre-panniculectomy BMI (Arthurs, 2007). Those with a BMI greater than 25 kg/m^2 were at nearly three times the risk of postoperative wound complications. Although those who experienced a plateau in weight loss at a BMI of 30-35 kg/m^2 did have the largest functional improvement from a panniculectomy, they also experienced the highest risk postoperatively. The average weight loss following bariatric surgery prior to panniculectomy was 116 ± 35 lbs. A limitation of this study was its retrospective design and sample size.

Acarturk (2004) compared the surgical outcomes of panniculectomy following bariatric surgery in another retrospective series of 123 participants (mean age 44.5 years). The outcomes of 21 participants with panniculectomy performed at the time of bariatric surgery were compared with the surgical outcomes of 102 participants who waited 17 ± 11 months to undergo panniculectomy. Overall, individuals who had panniculectomy simultaneously with bariatric surgery experienced more complications. Wound infections were 48% versus 16%; wound dehiscence 33% versus 13%; and there was a higher incidence (24% versus 0 %) of postoperative respiratory distress in individuals with the combined procedures. There were 3 postoperative deaths in the combined procedure cohort and none in the group that delayed panniculectomy until an average weight loss of 126 ± 59 lbs was achieved. The authors concluded that an initial period of substantial weight loss prior to the procedure results in a safer and more effective panniculectomy procedure.

The American Society of Plastic Surgeons (ASPS) Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and

Massive Weight Loss Patients (2007b) recommends that body contouring surgery, including panniculectomy, be performed only after an individual maintains a stable weight for 2 to 6 months. For individuals who are post-bariatric surgery, this is reported to occur 12-18 months after surgery when the BMI has reached the 25 kg/m^2 to 30 kg/m^2 range (Mechanick, 2013; Rubin, 2004). If performed prematurely, a potential exists for a second panniculus to develop once additional weight loss has occurred and the risks of postoperative complications are increased. Weight loss and BMI are important when considering panniculectomy and a significant amount of weight loss may not bring the BMI of an individual to less than 30 kg/m^2; however, a panniculectomy may still be necessary (Arthurs, 2007). The American Society for Metabolic and Bariatric Surgery Consensus statement states weight loss can vary from about 25% to 70% of an individual's excess body weight depending on the type of bariatric surgery that is performed (Buchwald, 2005).

A study by Zemlyak and colleagues (2012) reported on a retrospective review of individuals who had panniculectomy alone versus individuals who had panniculectomy and simultaneous ventral hernia repair. There were 143 participants in the panniculectomy/ventral hernia repair group and 42 participants in the panniculectomy group. The rates for incisional complications and interventions between the two groups were not statistically significant. However, after controlling for age, gender, BMI, subcutaneous use of talc, and intraoperative pulse-a-vac irrigation in the multivariate regression analysis, the group that had both panniculectomy and ventral hernia repair was more likely to develop wound cellulitis. The authors note that while panniculectomy with ventral hernia repair reduces the stress on the hernia repair and potentially decreases the recurrence rate, this potential advantage remains to be proven in robust comparative studies.

Fischer and colleagues (2014) conducted a large retrospective database analysis to assess the additional risk of ventral hernia repair (VHR) and panniculectomy (PAN) compared with hernia repair alone (n=55,537) using the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) data sets. To account for potential selection bias given the non-randomized assignment of concurrent panniculectomy and the retrospective study design, propensity scores were used which yielded two comparable groups, VHR (n=1250) and VHR+PAN (n=1250). The study authors found that individuals who underwent the combined procedure were at significantly higher risk for wound complications ($p<0.001$), venous thromboembolism ($p=0.044$), reoperation ($p<0.001$) and overall medical morbidity ($p<0.001$). Two notable limitations of this study include that the ACS-NSQIP dataset only includes 30-day outcomes, precluding analysis of long-term differences in the two study groups. Secondly, the dataset did not include details on the type of panniculectomy skin resection or wound closure techniques, therefore propensity matching, and exploratory analysis of these potentially confounding variables was not possible. Nonetheless, at 30-day follow-up in this large retrospective cohort, outcomes of panniculectomy performed with a concurrent ventral hernia repair appear to result in a significant increase in morbidity compared to VHR alone.

Giordano and colleagues (2017) published a retrospective study based on a prospectively maintained database of all consecutive midline abdominal wall reconstructions for an abdominal wall hernia or oncologic defect performed at a single site from 2005-2015. Of 548 consecutive surgeries, 305 individuals (56%) underwent abdominal wall reconstruction alone and 243 (44%) underwent abdominal wall reconstruction with concurrent panniculectomy. The mean follow-up period was 30 months. Prior to propensity matching, individuals with the combined procedure also had a higher number of previous abdominal surgeries and a larger mean abdominal wall defect size. After propensity matching, there were significantly higher incidences of fat necrosis, and surgical site abscess but no significant difference in hernia recurrence at follow-up. Abdominal wall reconstruction with concurrent panniculectomy was associated with higher wound morbidity with no difference in hernia recurrence rates in follow-up.

Derickson (2018) published results from retrospective review of all post-bariatric surgery cases who underwent panniculectomy over a 10-year period (n=706). The overall rate of complication was 56%: dehiscence (24%), surgical site infection (22%), seroma (18%), and post-operative bleeding (5%). A total of 12% of individuals necessitated a return to the operating room. The study demonstrated a high morbidity for post-bariatric panniculectomy and authors noted higher BMI, higher ASA class, and the use of fleur-de-lis incision were particularly associated with worse outcomes.

Nag and colleagues (2021) published results from another systematic review conducted by ACS-NSQIP to determine the benefit, if any, of adding panniculectomy to gynecologic surgery in obese and morbidly obese individuals. In total, 296 individuals were identified from the NSQIP database who fit the search criteria. A statistically significant association was found between the concomitant procedures and adverse outcomes, including superficial infection, wound infection, pulmonary embolism, sepsis, return to operating room, length of operation and length of stay. Furthermore, there was no significant benefit identified across the studies. Panniculectomy alone or with other abdominal surgical procedures, such as incisional or ventral hernia repair, or hysterectomy, is not clinically appropriate or an effective treatment of obesity. Recent meta-analyses have published mixed results of co-surgical procedures, but the studies lack documentation of a medical indication for removal of the pannus (Prodromidou, 2020; Rasmussen, 2017; Sosin, 2020). Although it has been suggested that the presence of a large overhanging panniculus may interfere with the surgery or compromise post-operative recovery, the presence of a pannus alone is not a medical condition which warrants surgical intervention. Removal of a pannus, for reasons other than those in the criteria for medical necessity is therefore considered cosmetic and not medically necessary.

Abdominoplasty

The literature addressing abdominoplasty and surgical repair of diastasis recti confirms the cosmetic benefits of these procedures. However, improvements in physical functioning, cessation of back pain, and other positive health outcomes have not been demonstrated. Carloni and colleagues conducted a systematic-review (2016) and confirmed that the quality of evidence surrounding abdominoplasty remains low and no standardization of surgical approaches has been established. Winocour (2015) reported results of a study which included 25,478 abdominoplasties and found high complication rates, compared to other cosmetic procedures, especially when abdominoplasty was combined with other procedures. Massenburg (2015) reported outcomes from 2946 abdominoplasties and found 8.5% of subjects were readmitted due to complications and 5% required revision surgery. Salari and colleagues (2021) conducted a systematic-review and meta-analysis to characterize the global prevalence of seroma following abdominoplasty and found the global prevalence following the procedure approaching 11% (95% CI, 9.3-3.6%). At this time, the evidence does not support abdominoplasty when done to remove excess abdominal skin or fat, with or without tightening lax anterior abdominal wall muscles, as an effective treatment for any medical condition, though it is an effective cosmetic procedure (ASPS Practice Parameter, 2007b).

Surgical procedures to correct diastasis recti are not effective for alleviating back pain or other non-cosmetic conditions. There is insufficient evidence to support the use of surgical procedures to correct diastasis recti for purposes other than cosmetic.

Similarly, the use of liposuction has been shown to produce cosmetic benefits in terms of appearance and body contour, however, liposuction has not been shown to be an effective treatment of obesity or other medical conditions and has been associated with significant complications, including death.

Definitions

Abdominoplasty: A procedure involving the removal of excess abdominal skin and fat with or without tightening lax anterior abdominal wall muscles and with or without repositioning or reconstruction of the navel.

Bariatric surgery: A variety of surgical procedures designed to treat obesity by either reconstructing the stomach or intestines or placing restrictive devices in or on the digestive tract.

Cellulitis: A diffuse, spreading inflammation of the deep tissues under the skin, and on occasion muscle, which may be associated with abscess formation.

Diastasis recti: A condition characterized by a separation between the left and right side of the rectus abdominis, which is the muscle covering the front surface of the chest (abdomen). A diastasis recti appears as a ridge running down the midline of the abdomen from the bottom of the breastbone to the navel.

Hysterectomy: Surgical removal of the uterus.

Incisional hernia: A condition where tissues or organs are able to push through a surgical incision or scar.

Intertrigo: An inflammation of the top layers of skin caused by moisture, bacteria, or fungi in the folds of the skin.

Liposuction: A surgical procedure designed to remove fat from under the skin via a suction device.

Panniculectomy: A procedure designed to remove fatty tissue and excess skin (panniculus) from the lower to middle portions of the abdomen.

Pubis: A part of the pelvic bone that is located in the groin, also called the pubic bone.

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History

Status	Date	Action
Reviewed	02/15/2024	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Discussion/General Information, References and Website sections.
Reviewed	02/16/2023	MPTAC review. Updated Discussion/General Information, References and Website sections.
Reviewed	02/17/2022	MPTAC review. Updated Discussion/General Information, References and Website sections. Updated Coding section; removed CPT anesthesia code 00802.
Reviewed	02/11/2021	MPTAC review. Revised MN definition text in the Description section. Updated Discussion/General Information, References and Website sections. Reformatted Coding section.
Reviewed	02/20/2020	MPTAC review. Updated References and Website sections.
New	03/21/2019	MPTAC review. Initial document development. Moved content of SURG.00048 Panniculectomy and Abdominoplasty to a new clinical utilization management guideline document with the same title. In the Cosmetic and Not Medically Necessary position statement section: (1) revised bullet “A” to indicate that liposuction is considered cosmetic and not medically necessary when used for the removal of excess abdominal fat; (2) revised bullet “C” by removing the words “for all indications”.
