

BSC7.04	Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti		
Original Policy Date:	January 1, 2002	Effective Date:	May 1, 2023
Section:	7.0 Surgery	Page:	Page 1 of 13

Policy Statement

The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines “reconstructive surgery” as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do **either** of the following (see also Blue Shield of California Medical Policy: Reconstructive Services):

- Create a normal appearance to the extent possible
- Improve function

Panniculectomy Standard Criteria

- I. Panniculectomy may be considered **medically necessary** when **all** of the following are met:
 - A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease
 - B. Documentation to support **either** of the following:
 1. For restoration of normal **appearance** when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs)
 2. For restoration of normal **function**. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances

Panniculectomy After Weight Loss

- II. Panniculectomy, **after weight loss**, may be considered **medically necessary** when **all** of the following are met:
 - A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease
 - B. Documentation to support **either** of the following:
 1. For restoration of normal **appearance** when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs)
 2. For restoration of normal **function**. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances
 - C. Documentation of **either** of the following:
 1. For non-surgical weight loss, maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight)
 2. If weight loss is the result of bariatric surgery, twelve months must pass after bariatric surgery before panniculectomy is performed and only when weight has been stable for at least six months

Abdominoplasty

- III. Abdominoplasty may be considered **medically necessary** when **all** of the following are met:
 - A. There is documentation of a **significant structural abnormality of the abdominal musculature** caused by a congenital defect, development abnormality, trauma, infection, tumors or disease
 - B. The purpose of the procedure is to **either**:
 - 1. Create a normal appearance to the extent possible
 - 2. Improve function

Diastasis Recti Repair

- IV. Repair of diastasis recti (alone or in combination with another abdominal procedure) is considered **not medical necessary** for all indications.
- V. Panniculectomy or abdominoplasty is considered **not medically necessary** for **any** of the following:
 - A. When there is no functional restoration needed meeting medically necessary criteria, the procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in [reconstructive surgery](#)
 - B. The treating surgeon has not provided sufficient documentation, including (when appropriate) quality color photographs or office records, which accurately depicts the extent of the clinical problem (see [Policy Guidelines](#) and [Documentation for Clinical Review](#) sections)
 - C. As an adjunct to other medically necessary procedures, including but not limited to, hysterectomy, and/or incisional or ventral hernia repair unless the above criteria are met
 - D. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes
 - E. The procedure is for [cosmetic](#) purposes only

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Based on the clinical judgment and the unique circumstances of each individual, Blue Shield of California reviewers have the discretion to approve any panniculectomy, regardless of the severity of the appearance of the panniculus or the severity of the complications, based on medical necessity.

Cosmetic surgery is distinguished from reconstructive surgery. Cosmetic surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

The technique of liposuction is considered **incidental** and included in the primary procedure. CPT code 15877 is used for liposuction; however, an unlisted CPT code may also be used.

There is no specific CPT code for repair of diastasis recti. A miscellaneous CPT code may be used.

For other procedures that may be requested at the same time as panniculectomy or abdominoplasty, such as brachioplasty, thighplasty, and circumferential body lift, consult the Medical Policy on Reconstructive Services.

Description

An abdominal panniculus is a redundant, large, and/or long overhanging apron of skin and subcutaneous fat located in the lower abdominal area. An abdominal panniculus is sometimes found

on patients with obesity, or in patients who have experienced massive weight loss. Panniculectomy is a body contouring surgical procedure that removes excess skin and subcutaneous tissue (fat) from the lower to middle portions of the abdomen, typically after massive weight loss. It may be performed as a standalone procedure or combined with an abdominoplasty (also known as a "tummy tuck"). Abdominoplasty reconstructs and tightens the abdominal muscle and removes excess skin and fat, while a panniculectomy only removes excess skin and fat (panniculus).

Diastasis recti is a condition characterized by separation between the left and right side of the rectus abdominis; however, it does not represent a "true" hernia. Surgical procedures such as abdominoplasty may be used to repair diastasis recti.

These procedures can be performed endoscopically or by open procedure, alone or in combination, in either the outpatient or inpatient setting. They are most often performed for cosmetic reasons. The following addresses the medically necessary or reconstructive indications.

Related Policies

- Reconstructive Services

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. 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.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibit plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

- N/A

Rationale

Panniculectomy and Abdominoplasty

A panniculus is often described as a massive apron of fat and skin over the abdomen. The condition often occurs in morbidly obese individuals following substantial weight loss, due to significant overstretching of the lax anterior abdominal wall.

The severity of the panniculus is graded on a scale of 1 to 5, with 5 being the most severe:¹

- 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

Surgical treatment of the redundant skin and fat is most often performed for cosmetic reasons to improve the appearance of the abdominal area. However, some individuals with a large abdominal panniculus may develop chronic skin irritation, intertrigo, infection, ulcers, and painful inflammation

of the subcutaneous adipose tissue (i.e., panniculitis) in the abdominal folds from chronic skin-on-skin contact. When panniculitis is severe, it may interfere with activities of daily living, such as personal hygiene and ambulation. Medical treatment of these skin conditions, in addition to proper personal hygiene practices, generally involves topical or systemic corticosteroids, topical antifungals, and topical or systemic antibiotics. Panniculectomy and wound closure may be required in chronic, severe cases where standard medical treatment has failed.

Panniculectomy is associated with substantial complication rates ranging from 12% to 51%, and major complications of hospitalization or surgical reintervention at rates of 10% to 15%.⁵ Complications include, but are not limited to, seroma, tissue necrosis, delayed healing, wound infection, hematoma, bleeding, and deep vein thrombosis.^{3,4} Complication rates were highest when panniculectomy was performed in conjunction with bariatric surgery or other procedures (i.e., hernia repair).⁵ Postbariatric body contouring (e.g., panniculectomy and abdominoplasty) is contraindicated in the following situations:⁶

- Unstable weight
- Non-compliance with lifestyle changes
- Unrealistic expectations of postoperative results such as contour irregularities, scarring, revisions, complications, prolonged recovery compression garments, and activity restrictions
- Smoking
- Malnutrition
- Unstable comorbidities
- Psychological instability

A weight loss of 100 plus pounds often leaves patients with a significant amount of loose hanging skin and tissue that can only be addressed with surgery.⁷ Panniculectomy is intended for patients with massive weight loss who are left with a large panniculus causing significant medical conditions that are unresponsive to medical treatment and negatively affecting quality of life.⁵ Massive weight loss is defined as a loss of 50% of excess weight.⁸ Panniculectomy, in contrast to abdominoplasty, does not include umbilicoplasty, undermining, and rectus muscle plication. The 2017 American Society of Plastic Surgeons (ASPS) Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients¹ indicated panniculectomy may be medically indicated if "panniculitis or chronic back pain have persisted despite an adequate trial of non-surgical management." Additionally, the individual should demonstrate weight stability for two to six months following a significant weight loss. For postbariatric surgery patients, this often occurs 12 to 18 months after surgery or at a basal metabolic index of 25 kilogram/milligram/squared (kg/mg^2) to 30 kg/mg^2 .^{1,6} If panniculectomy is performed prematurely, there is the potential for a secondary panniculus to develop once further weight loss has occurred. Further, studies have shown a reduction in postpanniculectomy complications in patients undergoing the procedure 18 months following bariatric surgery, compared with patients who underwent panniculectomy at the time of surgery.^{3,5,9} Additionally, Rubin⁶ stated "Before considering body contouring surgery the massive weight loss patient must be committed to maintaining lifestyle changes..." Colwell and Borud¹⁰, conducted a review of the literature on body contouring after massive weight loss and patient safety to provide a summary of current recommendations. The authors reported:

Literature consensus guidelines included completion and stabilization of weight loss before surgery with a body mass index ideally less than 32, smoking cessation, nutritional assessment, anemia screening, usage of mechanical prophylaxis against thromboembolism, and strong consideration for usage chemoprophylaxis with low molecular weight or unfractionated heparin.

The clinical significance of weight maintenance (stability) and weight loss is often questioned in studies that have provided marginal results. Two studies^{11,12} both operationally defined weight maintenance as a change of less than or equal to 5 pounds (2.3 kilograms [kg]). The 1998 Clinical

Guidelines on the Evaluation and Treatment of Overweight and Obesity in Adults¹³ defined successful weight maintenance after weight loss as a weight regain of less than 3 kg (6.6 pounds) in two years and sustained reduction in waist circumference of at least 4 centimeters. The Institute of Medicine (2002)¹⁴ defined weight loss maintenance as losing at least 5% of body weight, or reducing body mass index by at least one unit, and keeping weight below this minimum amount for at least one year. Stevens¹⁵ recommended a definition of weight maintenance as less than 3% change in body weight with greater than 5% change in body weight considered as clinically significant. These definitions are the product of observational studies, expert opinion, and review of the literature; however, randomized controlled trials have not been conducted. Thus, judgment of clinical significance requires further research and is under the interpretation of the reviewer.¹⁶

The ASPS Practice Parameter (2007) for Abdominoplasty and Panniculectomy Unrelated to Obesity or Massive Weight Loss² advised these procedures were most commonly performed for cosmetic indications such as "unacceptable appearance due to fat maldistribution or contour deformities caused by pregnancy, stretch marks, contracted scars and loose hanging skin after weight loss." The Practice Parameter additionally advised, in rare circumstances should panniculectomy be performed for reconstructive indications unrelated to obesity or significant weight loss. When abdominoplasty or panniculectomy are performed to solely enhance an individual's appearance in the absence of functional abnormalities, the procedure is considered cosmetic in nature. However, panniculectomy is considered reconstructive when performed to correct or relieve structural defects of the abdominal wall, irregularities or pain caused by prior pelvic or lower abdominal surgery, intertriginous skin conditions and scarring. Further, rarely is hernia repair in conjunction with abdominoplasty or panniculectomy required.

Review of current evidence is insufficient to consider panniculectomy a medically beneficial procedure when medical necessity or reconstructive criteria are not met. This includes the concurrent use of panniculectomy as an adjunct to other medical necessary procedures, including but not limited to, hysterectomy, gastric bypass, and/or incisional or ventral hernia repair. The medical literature has made some suggestion that the presence of a large panniculus may interfere with a surgery or postoperative recovery, indicating panniculectomy would improve surgical site access, promote postoperative wound healing, or minimize wound complications.^{15,17,18}

Abdominoplasty is a surgical procedure intended to tighten lax anterior abdominal wall muscles and remove excess abdominal skin and/or fat. The standard procedure consists of excision of redundant tissue (panniculectomy), undermining of the superior flap, umbilicoplasty (preservation of the umbilicus on its stalk and repositioning of the umbilicus), rectus muscle plication, and wound closure. In order to improve the appearance of a protuberant abdomen, the abdominal wall is recontoured to create a firmer and flatter abdomen. Cosmetic "mini" or "modified" abdominoplasties that do not involve muscle tightening or creation of a new navel have also been performed on patients with minimal to moderate defects, mild to moderate skin laxity, and muscle flaccidity (ASPS, 2007).² There is sufficient literature, predominantly individual case reports^{19,20} that discuss the cosmetic benefits of abdominoplasty; however, there is little evidence to support a significant health benefit (e.g., improvements in physical function or back pain).²¹⁻²⁴ While panniculectomy can be performed in morbidly obese individuals, abdominoplasty in most cases should not. The act of lifting skin and fat off the underlying muscle in abdominoplasty places these patients at a very high risk of complications. For these patients it is best to lose the weight surgically or non-surgically before undergoing abdominoplasty.

There has been no correlation established between the presence of abdominal wall laxity or redundant panniculus and the development of neck or back pain. The majority of studies evaluating panniculectomy after weight loss are retrospective and methodologically weak.^{8,24-25} There are no studies providing data regarding the impact of panniculectomy or abdominoplasty on clinical outcomes other than complications. The evidence is insufficient to

determine if panniculectomy effectively addressed medical conditions associated with a large panniculus such as back or groin pain.⁵

Diastasis Recti Repair

Diastasis recti, (also known as abdominal separation), is a disorder defined as a separation of the rectus abdominus muscle into right and left halves. Typically, the two sides of the muscle are joined by the linea alba at the body midline. The condition of diastasis recti presents as a weakness or laxity of the anterior abdominal wall; as such, it does not constitute a "true" hernia. A "true" hernia is reducible, and surgical "repair involves opening fascia and/or dissection of a hernia sac with return of intraperitoneal contents back to the peritoneal cavity" (ASPS, 2017).² Diastasis recti is not considered a structural abnormality based on the high prevalence of the condition in the general population, particularly newborn and pregnant women. Surgical procedures such as abdominoplasty may be used to correct diastasis recti however there is no demonstrated functional health benefit (e.g., relieving back pain or improvement of physical function). There is insufficient literature to indicate the presence of diastasis recti, in the absence of hernia, resulted in any clinically significant functional impairment or complications that required surgical intervention.²⁶ Accordingly, the Reconstructive Surgery Act (1998)²⁷ does not apply to diastasis recti repair (see Blue Shield of California Medical Policy: Reconstructive Services). Therefore, surgical repair of diastasis recti alone or in combination with another abdominal procedure is considered not medically necessary.

Liposuction

The surgical procedure of liposuction, also known as lipoplasty or suction-assisted lipectomy, is the removal of excess fat with the goal of recontouring the body and improving appearance. Liposuction is usually carried out on the buttocks, hips, thighs and abdomen. It can be performed alone or in conjunction with panniculectomy or abdominoplasty. The technique of liposuction has not been shown in clinical trials to provide additional benefits beyond standard surgical techniques. When liposuction is performed alone and not as part of a medically necessary procedure, it is considered not medically necessary. When the technique of liposuction is performed in combination with a medically necessary panniculectomy, it is considered incidental to the primary procedure.

Summary of Evidence

Panniculectomy is indicated for panniculitis that is unresponsive to good personal hygiene and conservative management as defined in the medically necessary criteria. There is insufficient evidence supporting abdominoplasty for other than cosmetic purposes. However, panniculectomy and/or abdominoplasty may be covered as reconstructive surgery consistent with existing California law in accordance with the Reconstructive Surgery Act, as discussed in the guidelines above.

References

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Indication for procedure
 - For non-surgical weight loss, documentation of maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight)
 - Office progress notes indicating type and duration of medically supervised conservative treatments caused by panniculus for chronic and persistent skin conditions
 - Procedure reports or treatment records pertaining to treatment of skin condition or structural abnormality (if applicable)
 - Dated frontal and lateral preoperative medical quality color photographs accurately confirming panniculus and chronic skin condition or extent of the clinical problem (photos of skin condition may require separation or lifting of the panniculus)
 - Date of bariatric procedure (if applicable)
 - Documentation provided that if weight loss is the result of bariatric surgery, 12 months has passed after bariatric surgery and weight has been stable for at least 6 months
 - Documentation of a significant structural abnormality of the abdominal musculature caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease if the requested service is for abdominoplasty.

Post Service (in addition to the above, please include the following):

- Operative report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
	15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
	15877	Suction assisted lipectomy; trunk
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/01/2002	Policy Revision Medical Management Guidelines (MMG) adopted and implemented
09/01/2003	Policy Revision Medical Management Guidelines (MMG) adopted and implemented
04/28/2008	Policy Revision Policy Name change from Abdominoplasty
11/04/2009	Coding Update
10/07/2011	Policy revision without position change
03/30/2015	Policy clarification
05/29/2015	Coding Update
09/30/2015	Policy revision without position change
01/01/2016	Administrative Update
04/01/2016	Administrative Update
07/01/2016	Policy revision without position change
07/01/2017	Policy revision without position change
07/01/2018	Policy statement clarification
08/01/2018	Policy revision without position change
07/01/2019	Policy revision without position change
05/01/2020	Annual review. Policy statement and guidelines updated.
05/01/2021	Annual review. No change to policy statement.
06/01/2022	Annual Review. Policy statement and guidelines updated.
05/01/2023	Annual Review. Policy statement updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE <u>Red font: Verbiage removed</u>	AFTER <u>Blue font: Verbiage Changes/Additions</u>
<p>Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti BSC7.04</p> <p>Policy Statement: The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following (see also Blue Shield of California Medical Policy: Reconstructive Services):</p> <ol style="list-style-type: none"> I. Create a normal appearance to the extent possible II. Improve function <p>Panniculectomy Standard Criteria Panniculectomy may be considered medically necessary when all of the following are met:</p> <ol style="list-style-type: none"> I. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease II. Documentation to support either of the following: <ol style="list-style-type: none"> A. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) B. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances 	<p>Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti BSC7.04</p> <p>Policy Statement: The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following (see also Blue Shield of California Medical Policy: Reconstructive Services):</p> <ul style="list-style-type: none"> • Create a normal appearance to the extent possible • Improve function <p>Panniculectomy Standard Criteria</p> <ol style="list-style-type: none"> I. Panniculectomy may be considered medically necessary when all of the following are met: <ol style="list-style-type: none"> A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease B. Documentation to support either of the following: <ol style="list-style-type: none"> 1. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) 2. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure

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<p>Panniculectomy After Weight Loss Panniculectomy, after weight loss, may be considered medically necessary when all of the following are met:</p> <ul style="list-style-type: none"> I. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease II. Documentation to support either of the following: <ul style="list-style-type: none"> A. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) B. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances III. Documentation of either of the following: <ul style="list-style-type: none"> A. For non-surgical weight loss, maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight) B. If weight loss is the result of bariatric surgery, twelve months must pass after bariatric surgery before panniculectomy is performed and only when weight has been stable for at least six months <p>Abdominoplasty Abdominoplasty may be considered medically necessary when all of the following are met:</p>	<p>when needed for exposure due to extraordinary circumstances</p> <p>Panniculectomy After Weight Loss</p> <ul style="list-style-type: none"> II. Panniculectomy, after weight loss, may be considered medically necessary when all of the following are met: <ul style="list-style-type: none"> A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease B. Documentation to support either of the following: <ul style="list-style-type: none"> 1. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) 2. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances C. Documentation of either of the following: <ul style="list-style-type: none"> 1. For non-surgical weight loss, maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight) 2. If weight loss is the result of bariatric surgery, twelve months must pass after bariatric surgery before panniculectomy is performed and only when weight has been stable for at least six months <p>Abdominoplasty</p>

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<p>I. There is documentation of a significant structural abnormality of the abdominal musculature caused by a congenital defect, development abnormality, trauma, infection, tumors or disease</p> <p>II. The purpose of the procedure is to either:</p> <p>A. Create a normal appearance to the extent possible</p> <p>B. Improve function</p> <p>Diastasis Recti Repair Repair of diastasis recti (alone or in combination with another abdominal procedure) is considered not medical necessary for all indications.</p> <p>Panniculectomy or abdominoplasty is considered not medically necessary for any of the following:</p> <p>I. When there is no functional restoration needed meeting medically necessary criteria, the procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by physicians specializing in <u>reconstructive surgery</u></p> <p>II. The treating surgeon has not provided sufficient documentation, including (when appropriate) quality color photographs or office records, which accurately depicts the extent of the clinical problem (see <u>Policy Guidelines</u> and <u>Documentation for Clinical Review</u> sections)</p> <p>III. As an adjunct to other medically necessary procedures, including but not limited to, hysterectomy, and/or incisional or ventral hernia repair unless the above criteria are met</p> <p>IV. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes</p> <p>V. The procedure is for <u>cosmetic</u> purposes only</p>	<p>III. Abdominoplasty may be considered medically necessary when all of the following are met:</p> <p>A. There is documentation of a significant structural abnormality of the abdominal musculature caused by a congenital defect, development abnormality, trauma, infection, tumors or disease</p> <p>B. The purpose of the procedure is to either:</p> <p>1. Create a normal appearance to the extent possible</p> <p>2. Improve function</p> <p>Diastasis Recti Repair IV. Repair of diastasis recti (alone or in combination with another abdominal procedure) is considered not medical necessary for all indications.</p> <p>V. Panniculectomy or abdominoplasty is considered not medically necessary for any of the following:</p> <p>A. When there is no functional restoration needed meeting medically necessary criteria, the procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in <u>reconstructive surgery</u></p> <p>B. The treating surgeon has not provided sufficient documentation, including (when appropriate) quality color photographs or office records, which accurately depicts the extent of the clinical problem (see <u>Policy Guidelines</u> and <u>Documentation for Clinical Review</u> sections)</p> <p>C. As an adjunct to other medically necessary procedures, including but not limited to, hysterectomy, and/or incisional or ventral hernia repair unless the above criteria are met</p> <p>D. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes</p> <p>E. The procedure is for <u>cosmetic</u> purposes only</p>