Subject: Panniculectomy and Abdominoplasty

Medical Policy #: 16.5
Status: Reviewed

Original Effective Date: 06/28/2006
Last Review Date: 03/24/2021

Disclaimer

Refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

An abdominoplasty (also known as a “tummy tuck”) is a cosmetic surgical procedure to remove excess abdominal skin and fat and tighten a lax anterior abdominal wall. A panniculectomy is a reconstructive surgery to remove a panniculus, also called a pannus. The pannus is an overhanging apron of skin and subcutaneous fat in the lower abdominal area. A massive pannus can cause chronic and persistent skin conditions, as well as interfere with activities of daily living.

Panniculectomy- Abdominal Lipectomy/panniculectomy is surgical removal of excessive fat and skin from the abdomen. When surgery is performed to alleviate such complicating factors as inability to walk normally, chronic pain, ulceration created by the abdominal skin fold, or intertrigo dermatitis, such surgery is considered reconstructive.

Coverage Determination

Prior Authorization is required. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

Coverage Determination:

For Commercial, Medicaid and Medicare, Presbyterian follows CMS Local Coverage Determination (LCD) Cosmetic and Reconstructive Surgery (L35090) and the related article (A56587). Please see Covered Indications (2) Abdominal Lipectomy/Panniculectomy.

Documentation Requirements

Abdominal lipectomy/panniculectomy
The beneficiary’s medical record must contain the following information:

- Description of the pannus and the underlying skin.
- Documentation that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing).
- Description of conservative treatment undertaken and its results.

Exclusions

1. Liposuction (15877) is generally considered cosmetic and is non-covered. See LCA Article (A57475), (see Group 3).
2. Abdominoplasty or panniculectomy are not covered when performed primarily for any of the following indications because it is considered cosmetic and not medically necessary (this list may not be all inclusive):
   - Treatment of neck or back pain.
   - Improving appearance (i.e., cosmetic).
   - Repairing abdominal wall laxity or diastasis recti.
   - Treating psychological disease, syndromes and symptoms or psychosocial complaints.
   - Treating disparities associated with body image and gender identity.
   - When performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy and abdominoplasty are met separately.
2. Panniculectomy is considered experimental and investigational for minimizing the risk of hernia formation or recurrence. There is no 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.
3. Panniculectomy is non-covered as primary treatment for back, hip, knee pain or dysfunction associated with osteoarthritis, vertebral or intervertebral disc disease or nerve compression syndromes.
4. Panniculectomy or removal of excess skin and soft tissue of the abdomen, chest, breasts, buttocks, and extremities is non-covered to treat redundancies resulting from weight loss or weight loss surgery when that tissue is without evidence of chronic infection, inflammation or ongoing necrosis post 3 months of appropriate therapy for the etiologic factor.

Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].
The coding listed in this Medical Policy is for reference only and is not meant to be exclusive of other possible CPT, HCPCS or ICD-10 codes. Covered and non-covered codes are within this list.


<table>
<thead>
<tr>
<th>CPT</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>15847</td>
<td>Excision, excessive skin and subcutaneous tissue, (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication), (listed separately in addition to code for primary procedure)</td>
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</tbody>
</table>

**Abdominoplasty and circumferential lipectomy are considered cosmetic procedures and are usually NON-COVERED**

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>15877</td>
<td>Liposuction, trunk.</td>
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### ICD-10 Diagnosis

<table>
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<tr>
<th>ICD-10 codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E65</td>
<td>Local adiposity (fat pad)</td>
</tr>
<tr>
<td>L03.319</td>
<td>Cellulitis - trunk</td>
</tr>
<tr>
<td>L26</td>
<td>Exfoliative dermatitis</td>
</tr>
<tr>
<td>L30.4</td>
<td>Erythema intertrigo</td>
</tr>
<tr>
<td>L53.8</td>
<td>Other specified erythematos conditions</td>
</tr>
<tr>
<td>M79.3</td>
<td>Panniculitis, unspecified</td>
</tr>
</tbody>
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### References

1. CMS – LCD L35090 Cosmetic and Reconstructive Surgery, Revision date: 11/07/2019, R#6. [Cited 01-26-2021]
3. CMS, Local Coverage Article (A56587), Billing and Coding: Cosmetic and Reconstructive Surgery, Revision date: 01/01/2021, R#4. [Cited 01-26-2021]
4. CMS IOM Publication [100-02, Medicare Benefit Policy Manual, Chapter 16](https://www.cms.gov/medicare/medicare-benefits-policy-manual-bcm/index.html), Section 10, General Exclusions from Coverage, Section 120 Cosmetic Surgery and Section 180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.
5. CMS [MLN Booklet, Items and Services Not Covered Under Medicare](https://www.cms.gov/MLNProducts/MLNProducts.aspx), Section F Cosmetic Surgery, ICN 906765 August 2018. [Cited 02/26/2021]

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**Clinical Quality & Utilization Mgmt. Committee:** Howard Epstein MD  
**Senior Medical Director:** Norman White MD  
**Date Approved:** 03/24/2021  

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Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].
This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such. For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: Click here for Medical Policies

Web links:
At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].