BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

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PANNICULECTOMY, ABDOMINAL

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

Description:

The "overhanging" apron of redundant skin and fat in the lower abdominal area is known as a panniculus. The panniculus may cause chronic intertrigo, dermatitis occurring in the skin folds, skin irritation, and infection or chafing.

Panniculectomy is the excision of excessive skin and subcutaneous tissue (includes lipectomy) of the abdomen and includes umbilical transposition.

Abdominoplasty is the excision of excessive skin and subcutaneous tissue (includes lipectomy) of the abdomen and includes umbilical transposition and fascial plication.

PANNICULECTOMY, ABDOMINAL (cont.)

Criteria:

Photographs of the abdominal panniculus (anterior/posterior and lateral views) are required to determine medical necessity.

- Panniculectomy for the treatment of abdominal panniculus is considered ***medically necessary*** with documentation of **ONE** of the following:

  1. Chronic intertrigo:

     - Chronic maceration of overhanging skin folds with failure to respond to three (3) months or more of conservative treatment with oral and/or topical medication, **or**
     - Four or more recurrent skin infections per year under the panniculus with failure to respond to conservative treatment that includes oral and/or IV antibiotics, and/or antifungal agents and good hygiene/wound care.

  2. Performed in conjunction with repair of a symptomatic abdominal wall hernia [1]

- If above criteria not met, panniculectomy for the treatment of abdominal panniculus is considered ***cosmetic*** and ***not eligible for coverage***.

- Abdominoplasty for the treatment of abdominal panniculus is considered ***cosmetic*** and ***not eligible for coverage***.

[1] Panniculectomy performed in conjunction with repair of a symptomatic abdominal wall hernia is considered a secondary procedure.

Resources:

1. InterQual® Care Planning, Procedures. Panniculectomy, Abdominal.