APPENDIX to Panniculectomy, Abdominoplasty and Surgical Management of Diastasis Recti Policy

Prior Authorization Requirements

Clinical Evidence is required to determine **medical necessity**.

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 also be directed to the Prior Authorization Department. Please call 1-800-541-6652 or visit the Provider Portal www.blueshieldca.com/provider.

Evidence Basis for the Policy

Rationale

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 (American Society of Plastic Surgeons (ASPS), 2007):

- 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% (Hayes, Inc., 2010). Complications include, but are not limited to, seroma, tissue necrosis, delayed healing, wound infection, hematoma, bleeding, and deep vein thrombosis (Authurs et al., 2007; Leahy et al., 2008). Complication rates were highest when panniculectomy was performed in conjunction with bariatric surgery or other procedures (i.e., hernia repair) (Hayes, Inc., 2010). Postbariatric body countouring (e.g., panniculectomy and abdominoplasty) is contraindicated in the following situations (Rubin et al., 2004):

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

A weight loss of 100+ pounds often leaves patients with a significant amount of loose hanging skin and tissue that can only be addressed with surgery (Boswell, 2010). 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 (Hayes Inc., 2010). Massive weight loss is defined as a loss of 50% of excess weight (Manahan et al., 2006). Panniculectomy, in contrast to abdominoplasty, does not include umbilicoplasty, undermining, and rectus muscle plication. The 2007 American Society of Plastic Surgeons (ASPS) Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients indicated body contouring surgery or panniculectomy was medically indicated if panniculitis or uncontrollable intertrigo were present. 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 (Rubin et al., 2004; ASPS, 2007; Batra & Sardo, 2008). 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 (Acaturk et al., 2004; Arthurs et al., 2007; Hayes, Inc., 2010). Additionally, Rubin et al., (2004) stated "Before considering body contouring surgery the massive weight loss patient must be committed to maintaining lifestyle changes..." Colwell and Borud, (2008) 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. St Jeor et al., (1997) and Sherwood et al., (2000) both operationally defined weight maintenance as a change of </= 5 pounds (2.3 kilograms (kg)). The 1998 Clinical Guidelines on the Evaluation and Treatment of Overweight and Obesity in Adults defined successful weight maintenance after weight loss as a weight regain of < 3 kg (6.6 pounds) in two years and sustained reduction in waist circumference of at least 4 centimeters. The Institute of Medicine (2002) 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. Stevens et al., (2006) recommended a definition of weight maintenance as < 3% change in body weight with > 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 (Donnelly et al., 2010).

The ASPS Practice Parameter (2007) for Abdominoplasty and Panniculectomy Unrelated to Obesity or Massive Weight Loss 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, irregularites 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 (ASPS, 2007).

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 (Stevens et al., 2004; Wright et al., 2004; Olejek & Manka, 2005). A 2009 Hayes, Inc., Search and Summary report advised there were insufficient studies to conduct an evidenced-based assessment regarding the safety and efficacy of panniculectomy when combined with any type of gynecological surgery. Performing panniculectomy is not essential for a successful clinical outcome of an abdominal or gynecologic surgical procedure. The evidence is insufficient to

support these proposed benefits in the absence of chronic or persistent skin conditions interfering with activities of daily living.

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). There is sufficient literature, predominantly individual case reports (Espinosa-de-los-Monteros, 2006; Fraccalviera et al., 2007) 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) (Toranto, 1988; Ellaban et al., 2003; Corridi et al., 2011; Nahas, 2011). 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 (Manahan & Shermak, 2006; Nahas, 2011; Oneal et al., 2011). 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 (Hayes, Inc., 2010).

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, 2007). 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 (Jeyarajah & Harford, 2010). Accordingly, the Reconstructive Surgery Act (1998) does not apply to diastasis recti repair (see the Reconstructive Services Medical Policy). Therefore, surgical repair of diastasis recti alone or in combination with another abdominal procedure is considered not medically necessary.

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 cosmetic in nature. When the technique of liposuction is performed in combination with a medically necessary panniculectomy, it is considered incidental to the primary procedure.

In summary, 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, in rare circumstances, panniculectomy and/or abdominoplasty may be covered as reconstructive surgery consistent with existing California law in accordance with the Reconstructive Surgery Act.

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.

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement Policy

Type	Number	Description
CPT	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
	15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
	15877	Suction assisted lipectomy; trunk

Type	Number	Description
HCPC	None	
ICD9 Procedure		
	83.65	Other suture of muscle or fascia
	86.83	Size reduction plastic operation
ICD9 Diagnosis	All Diagnoses	
Place of Service	All Places of Service	

Tables

N/A

Definitions

Intertrigo - Dermatitis occurring between folds or juxtaposed surfaces of the skin caused by sweat retention, moisture, warmth, and the overgrowth of resident microorganisms (i.e., bacteria, fungi).

Symphysis pubis - The area in the front of the pelvis where the pubic bones (the two bones of the pubis) meet.

Index / Cross Reference of Related BSC Medical Policies

The following Medical Policies share diagnoses and/or are equivalent BSC Medical Policies:

- Reconstructive Services

Key / Related Searchable Words

N/A

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Policy History

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

Effective Date	Action	Reason
1/1/2002	Policy Revision Medical Management Guidelines (MMG) adopted and implemented	BSC Medical Management Guidelines
9/1/2003	Policy Revision Medical Management Guidelines (MMG) adopted and implemented	Medical Policy Committee
4/28/2008	Policy Revision Policy Name change from Abdominoplasty	Medical Policy Committee

Effective Date	Action	Reason
11/4/2009	Coding Update	Administrative Review
10/7/2011	Policy revision without position change	Medical Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

Click here to view the policy statement for this policy

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