blue of california

Medical Policy

Panniculectomy, Abdominoplasty and Surgical Management of Diastasis Recti	
Type: Medical Necessity/Not Medical Necessity	**Policy Specific Section:** Surgery
Original Policy Date: January 1, 2002	**Effective Date:** October 7, 2011

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

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 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.

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, 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.

Policy

Coverage for panniculectomy, abdominoplasty and repair of diastasis recti is dependent on benefit plan language, and may be subject to the provisions of a cosmetic and/or **reconstructive** surgery benefit and the Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88). Please refer to the applicable benefit plan language to determine the terms, conditions and limitations of coverage.

Coverage for panniculectomy and/or abdominoplasty may require independent consideration of whether the surgery is considered **medically necessary** or **reconstructive** (see the Reconstructive Services Medical Policy). If services are mandated coverage under the Reconstructive Surgery Act; no further determination of medical necessity is required. If services are determined not to be covered under the Reconstructive Surgery Act; a subsequent determination of medical necessity or non-medical necessity must be made.

Panniculectomy

Panniculectomy may be considered **medically necessary** for an individual when **all** of the following criteria are met:

- Panniculus hangs at or below the level of the symphysis pubis (documented by clinical preoperative frontal and lateral photographs)
- 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 (e.g., in addition to good hygiene practice, topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics)
- History of significant weight loss and documented evidence of the following:
    - For non-surgical weight loss, maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain (+/- 5%))
    - 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

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Note: Even when a panniculectomy is considered not medically necessary, the procedure may be considered **reconstructive** according to the Reconstructive Surgery Act when performed to correct or relieve structural defects of the abdominal wall. See the Reconstructive Services Medical Policy for further information.

Panniculectomy may be considered **medically necessary** as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances.

Panniculectomy is considered **not medically necessary** as an adjunct to other medical necessary procedures, including but not limited to, hysterectomy, and/or incisional or ventral hernia repair unless the above criteria are met.

Abdominoplasty

Abdominoplasty is considered **cosmetic;** however may be considered **reconstructive** according to the Reconstructive Surgery Act when there is documentation of structural abnormality of the abdominal musculature caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease to do **either** of the following:

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

Note: See the Reconstructive Services Medical Policy for further information.

Diastasis Recti Repair

Repair of diastasis recti, alone or in combination with another abdominal procedure, is considered **not medically necessary** for all indications.

Policy Guideline

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.

Internal Information

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htm

Documentation Required for Clinical Review
• History and physical, and/or consultation notes including: indication for procedure • Weight over the past six months, including current height and weight

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- Office progress notes indicating type and duration of medically supervised conservative treatments (e.g., for skin conditions)
- Procedure reports or treatment records pertaining the treatment of skin condition or structural abnormality (if applicable)
- Dated frontal and lateral preoperative quality clinical photographs confirming panniculus and chronic skin condition (photos of skin condition may require separation or lifting of the panniculus)
- Date of bariatric procedure (if applicable)

Post Service

- Operative report(s)

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 appendix for this policy

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