BlueCross BlueShield of Arizona
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MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

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LIPOMA TREATMENT

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 & 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:

A lipoma is a subcutaneous mass of fat. Potential treatments include excisional lipectomy and suction assisted lipectomy.

Excisional Lipectomy:
Excision of excessive skin and subcutaneous tissue.

Suction Assisted Lipectomy (Liposuction/Suction Curettage):
The removal of fat cells by suction through small incisions made in the skin.

Definitions:

Functional Impairment:
A state in which the normal or proper action of any body part or organ is damaged or deficient as a result of a lipoma.

LIPOMA TREATMENT (cont.)

Criteria:

COVERAGE FOR TREATMENT TO CORRECT A CONGENITAL DEFECT OR BIRTH ABNORMALITY IS DEPENDENT UPON BENEFIT PLAN LANGUAGE AND IS SUBJECT TO THE PROVISIONS OF THE RECONSTRUCTIVE BENEFIT AND THE COSMETIC BENEFIT EXCLUSION. REFER TO MEMBER'S SPECIFIC BENEFIT PLAN BOOKLET TO VERIFY BENEFITS AND THE FUNCTIONAL IMPAIRMENT REQUIREMENT.

- Excisional or suction assisted lipectomy for the removal of a lipoma may be considered ***medically necessary*** based upon clinical documentation of a mass by physical examination that is **ONE** of the following:

  1. Symptomatic (e.g., bleeding, pain)
  2. Causing a functional impairment (see Definition section)

- Excisional or suction assisted lipectomy for all other indications is considered ***cosmetic*** **AND** considered ***not medically necessary*** due to the lack of an associated functional impairment.

Resources:

1. American Medical Association. 2005 Current Procedural Terminology, (CPT ®).
2. American Society of Plast7ic Surgeons. Practice Advisory on Liposuction: Executive Summary. 03/15/2003, Accessed 12/21/2005.
3. American Society of Plastic Surgeons. Cosmetic Plastic Surgery Procedures at a Glance. Accessed 12/21/2005.
4. American Society of Plastic Surgeons. Liposuction. Accessed 12/17/2007.
5. FDA. The Skinny on Liposuction. 08/20/2007.
6. InterQual ® Care Planning, Procedures Adult. Liposuction.
7. National Library of Medicine. Liposuction. 05/03/2007.
8. Ronald E. Iverson MD, Dennis J. Lynch MD, ASPS Committee on Patient Safety, Cosmetic Special Topic Practice Advisory on Liposuction. Accessed 12/21/2005, 03/18/2010.
9. Taber's ® Cyclopedic Medical Dictionary. Edition 19. 2001 2001.