

Clinical Policy: Panniculectomy

Reference Number: CP.MP.109

Date of Last Revision: 08/24

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Description

Panniculectomy is the surgical removal of a panniculus or excess skin and adipose tissue that hangs down over the genital and/or thigh area causing difficulty in personal hygiene, walking, and other physical activity.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation that panniculectomy is considered **medically necessary** when meeting all of the following indications:
 - A. Panniculus hangs below the level of the pubis, documented by photographs;
 - B. Medical records and photographs document at least one of the following chronic and persistent complications that remains refractory to appropriate therapy for at least three months. Appropriate medical therapy includes topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics, in addition to good hygiene practices;
 1. Non-healing ulceration under panniculus;
 2. Chronic maceration or necrosis of overhanging skin folds;
 3. Recurrent or persistent skin infection under panniculus;
 4. Intertriginous dermatitis or cellulitis or panniculitis;
 - C. Panniculectomy is expected to restore normal function or improve functional deficit;
 - D. If panniculus is due to significant weight loss, one of the following:
 1. Weight loss is not a result of bariatric surgery and there is evidence that a stable weight has been maintained for at least six months;
 2. Weight loss is the result of bariatric surgery, weight has been stable for at least six months, and it has been at least 18 months since surgery.

Background

Panniculectomy is a surgical procedure to remove an abdominal pannus or panniculus. A panniculus is formed secondary to obesity when there is a dense layer of fatty tissue growth on the abdomen that becomes large enough to hang down from the body. Panniculus size varies from grade 1, which reaches the mons pubis, to grade 5, which extends to or reaches past the knees.

Some areas of difficulty associated with a panniculus are personal hygiene, walking, and other physical activities. Sores and infections such as intertrigo, skin ulcers, and panniculitis can form in the folds of the panniculus, leading to painful inflammation of the tissue. This can further hinder physical activity and activities of daily life.

Panniculectomy is very similar to abdominoplasty, a surgical procedure that tightens the lax anterior abdominal wall muscles and trims excess adipose tissue and skin. Panniculectomy differs from abdominoplasty in the sense that abdominoplasty is usually performed as a cosmetic procedure to improve appearance but not function. Panniculectomy can be necessary for

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restoring normal function or improving functional deficit as well as preventing sores and infections.

Coding Implications

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CPT® Codes	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Criteria separated from CP.MP.31 Cosmetic and Reconstructive Surgery	04/16	04/16
References reviewed and updated.	03/19	03/19
ICD -10 codes added. References reviewed and updated. Specialist reviewed.	02/20	03/20
Annual review. Replaced all instances of member with member/enrollee. Expanded criteria for complications related to pannus to include non-healing ulceration under panniculus, chronic maceration or necrosis of overhanging skin folds, recurrent or persistent skin infection under panniculus, intertriginous dermatitis or cellulitis or panniculitis. Added the following ICD 10 codes: L03.319, L03.818, L98.499. Separated “D.” into separate criteria points, D. and E, adding that bariatric surgery weight loss must be stable for 6 months.	02/21	03/21
Annual review. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed, updated, and reformatted. Minor verbiage changes with no clinical significance. Reviewed by specialist.	11/21	11/21
Annual review. Removed ICD-10 codes. References reviewed and updated.	10/22	10/22
Annual Review. Combined criteria I.D. and E. into criteria I.D.1. and 2. Removed CPT code 00802 from policy. References reviewed and updated. Reviewed by external specialist.	10/23	10/23
Annual review. References reviewed and updated.	08/24	08/24

References

- American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Abdominoplasty and Panniculectomy Unrelated to Obesity

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- or Massive Weight Loss. Published July 2006. (reaffirmed March 2019). Accessed July 16, 2024.
2. Courcoulas AP, Christian NJ, Belle SH, et al. Weight change and health outcomes at 3 years after bariatric surgery among individuals with severe obesity. *JAMA*. 2013;310(22):2416-2425. doi:10.1001/jama.2013.280928
 3. American Society of Plastic Surgeons (ASPS). Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. Published June 2017. Accessed July 16, 2024.
 4. Sachs D, Sequeira Campos M, Murray J. Panniculectomy. In: *StatPearls*. Treasure Island (FL): StatPearls Publishing; July 19, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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