

Clinical Policy: Panniculectomy

Reference Number: CP.MP.109

Last Review Date: 03/20

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

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 chronic and persistent intertrigo that remains refractory to appropriate therapy for at least 3 months. Appropriate medical therapy includes topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics, in addition to good hygiene practices;
 - C. Panniculectomy is expected to restore normal function or improve functional deficit;
 - D. *If* panniculus is due to significant weight loss, there must be evidence that member has maintained a stable weight for at least 6 months. If weight loss is the result of bariatric surgery, it must also be 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 restoring normal function or improving functional deficit as well as preventing sores and infections.

Coding Implications

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CLINICAL POLICY

Panniculectomy

2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD 10 CM Code	Description
L30.4	Erythema intertrigo
M79.3	Panniculitis, unspecified
Z98.84	Bariatric surgery status

Reviews, Revisions, and Approvals	Date	Approval Date
Criteria separated from CP.MP.31 Cosmetic and Reconstructive Surgery	04/16	04/16
References reviewed and updated.	04/17	04/17
Changed wording in I.D for clarification that weight should be stable after bariatric surgery.	02/18	03/18
References reviewed and updated.	03/19	03/19
ICD -10 codes added. References reviewed and updated. Specialist reviewed.	02/20	03/20

References

- American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Abdominoplasty and Panniculectomy Unrelated to Obesity or Massive Weight Loss. 2006 Jul. Last approved 03/19. Accessed Feb 6, 2020.
- Gallagher, S. Gates JL. . Obesity, panniculitis, panniculectomy, and wound care: Understanding the challenges. J Wound Ostomy Continence Nurs. 2003 Nov;30(6):334-41..
- Hayes Technology Assessment. Panniculectomy for abdominal contouring following massive weight loss. Lansdale, PA: Hayes, Inc. © 2012 Winifred S. Hayes, Inc. Archived Oct 19, 2015.
- Panniculectomy for treatment of symptomatic panniculi. Lansdale, PA: Hayes, Inc. © 2012 Winifred S. Hayes, Inc. Annual review: June 12, 2019.

CLINICAL POLICY

Panniculectomy

5. Courcoulas, Anita P, et.al. (2013). 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. Published online November 4, 2013. .
6. American Society of Plastic Surgeons (ASPS). Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. June 2017. Accessed Feb 6, 2020

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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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CLINICAL POLICY

Panniculectomy

by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, 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, 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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