MN.021.B Panniculectomy and Abdominoplasty

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Thank you for being a valued provider for members in one or more of our health plans: Jefferson Health Plans Medicare Advantage, Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans CHIP, and/or Jefferson Health Plans EverWell (our Medicaid plan).

PRODUCT VARIATIONS

This policy only applies to Jefferson Health Plans EverWell and Jefferson Health Plans CHIP product lines.

This policy does not apply to Individual and Family Plans (ACA) product.

Medicare Variation

Related Local Coverage Determination (LCD) L35090 Cosmetic and Reconstructive Surgery.

POLICY STATEMENT

PANNICULECTOMY

We consider panniculectomy medically necessary when the following criteria are met:

1. The panniculus hangs below the level of the pubis (distal end of the symphysis pubis) and covers genitals and upper thighs crease (Grade 2).

2. The panniculus is causing persistent intertriginous dermatitis, cellulitis, or skin ulceration, which is refractory to at least three (3) months of physician directed treatment, including all applicable treatments (topical and/or oral antifungals, antibiotics, corticosteroids.) Medical records should include medications used and duration of treatment.

3. The panniculus is interfering with activities of daily living such as inability to walk independently and requires assistive devices such as a cane etc., or inability to clean under panniculus and maintain proper hygiene etc.

4. The surgery is expected to restore or improve the functional deficit

A panniculus extending past the upper thigh (Grade 3 or greater) can be approved for panniculectomy with or without documentation of failed treatment for any active intertrigo.

If a panniculectomy is being performed after significant weight loss, in addition to meeting the criteria noted above, there should be documented evidence that the patient has maintained a constant stable weight for at least six months. If the weight loss is the result of bariatric surgery, panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months and the BMI is less than 35.

Panniculectomy requests to treat back pain are not medically necessary.

ABDOMINOPLASTY

We consider abdominoplasty cosmetic in nature and **not medically necessary** for ANY indication, including but not limited to the following:

- Repairing abdominal wall laxity.

- Treatment of neck or back pain.

- Treating psychological symptomatology or psychosocial complaints.

- When performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery.)

POLICY GUIDELINES

Grading Scale:

- **Grade 1:** the panniculus reaches the pubic hair but not the genitals.
- **Grade 2:** the panniculus lies over the genitals down to the thigh crease.
- **Grade 3:** the panniculus reaches down to the upper thigh.
- **Grade 4:** the panniculus hangs down to mid-thigh level.
- **Grade 5:** the panniculus reaches the knees.

Documentation Requirements

Medical notes documenting the following, when applicable:

- Functional limitations due to pannus.
- High-quality color photographs. (For panniculectomy, photographs of a full-frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows any skin damage to be evaluated, and a full-lateral view of the hanging pannus).
- Intertriginous rashes or other skin problems with documentation of treatment and response.
- Primary complaint, history of complaint and physical exam.

Note: All photographs must be labeled with the:

- Applicable case number obtained at time of notification, or the member's name and ID number on the photographs.
- Date taken.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services,

providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

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CPT Code	Description
15830 Covered when criteria met	Excision, excessive skin, and subcutaneous tissue (Includes lipectomy); abdomen, infraumbilical panniculectomy
15847 Non-covered	Excision, excessive skin, and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)

HCPCS Code	Description
N/A	N/A

ICD-10 Codes	Description
M79.3	Panniculitis, unspecified.
L30.4	Erythema intertrigo.
L98.7	Excessive and redundant skin and subcutaneous tissue.

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the members' benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible

benefit as defined in the Member's applicable benefit contract on the date the service was rendered. Services determined by the plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

DEFINITIONS

Abdominoplasty: Typically performed for cosmetic purposes, involves the removal of excess skin and fat from the pubis to the umbilicus or above, and may include fascial plication of the rectus muscle diastasis and a neoumbilicoplasty.

Panniculectomy: Involves the removal of hanging excess skin/fat in a transverse or vertical wedge but does not include muscle plication, neoumbilicoplasty or flap elevation. Cosmetic Abdominoplasty is sometimes performed at the time of a functional Panniculectomy.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

For Jefferson Health Plans EverWell and Jefferson Health Plans CHIP products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2026 Review. Revision to policy statement and guidelines.	B	07/15/2026
2025 Annual Review. References updated accordingly.	A	02/01/2023
2024 Annual review. No changes required.	A	02/01/2023
2023 Annual review. No changes required.	A	02/01/2023

This is a new policy.	A	02/01/2023

REFERENCES

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