Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP056

Section: Medical Benefit Policy

Subject: Management of Excessive Skin and Subcutaneous Tissue

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Management of Excessive Skin and Subcutaneous Tissue

II. Purpose/Objective:

To provide a policy of coverage regarding Management of Excessive Skin and Subcutaneous Tissue

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an

illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:
Panniculectomy, Lipectomy, Liposuction, Abdominoplasty:
Defined as excision of excessive skin and subcutaneous tissue including but not limited to Panniculectomy (Abdominoplasty) or Lipectomy by any other method (excision, suction assisted, liposuction, aspiration) and may involve areas such as but not limited to head and neck, upper and lower extremities, abdomen, breasts, back, pelvis, buttocks, hips and other areas not specifically listed.

INDICATIONS: <u>REQUIRES PRIOR MEDICAL DIRECTOR or DESIGNEE AUTHORIZATION (For lines of business in which coverage is not explicitly excluded).</u>

A member enrolled in a contract in which coverage is not explicitly excluded, may be eligible for an abdominoplasty or panniculectomy when **ALL** the following are met:

1. The pannus hangs below the level of the pubis; **AND**
2. One of the following:
    a. medical documentation of recurrent or chronic rashes, infections, chronic or recurrent intertrigo, candidiasis, cellulitis or tissue necrosis with inpatient or outpatient follow-up required; **OR**
    b. medical documentation of difficulty with ambulation and interference with the activities of daily living; **AND**
3. Symptoms or functional impairment persists despite significant weight loss defined as at least a 100 lb. weight loss or a weight loss which is 40% or greater of the excess body weight that was present prior to the member's weight loss program or surgical intervention, which has been stable for at least 3 months; **AND**
4. If the member has had bariatric surgery, they are at least 12 months post-operative and have documented stable weight for at least 3 months.

A member, enrolled in a contract in which coverage is not explicitly excluded, may be eligible for surgical management of excessive skin and subcutaneous tissue when ALL the following are met:

One of the following:
    a. medical documentation of recurrent or chronic rashes, infections, chronic or recurrent intertrigo, candidiasis, cellulitis or tissue necrosis with inpatient or outpatient follow-up required; **OR**
    b. medical documentation of difficulty with ambulation and/or interference with the activities of daily living; **AND**

If the member has had bariatric surgery, they are at least 12 months post-operative and have documented stable weight for at least 3 months

EXCLUSIONS:
Members may **NOT** be eligible for surgical management of excessive skin and subcutaneous tissue for any indications other than those listed above, including but not limited to:

- Restorative or reconstructive surgery performed for cosmetic purposes and from which no significantly improved physiologic function as determined by the Plan is anticipated, is **NOT COVERED**.

- Repair of a diastasis, defined as a thinning of the anterior abdominal wall fascia, in the absence of a true midline (ventral) hernia, is not considered medically necessary because it is not associated with conditions of clinical significance.

- Solely to treat back pain, or when performed in conjunction with abdominal or gynecological procedures (e.g. abdominal hernia repair, hysterectomy), unless the above criteria for panniculectomy or abdominoplasty are met separately.

The Plan does not provide coverage for abdominal suction-assisted lipectomy or liposuction because it is considered cosmetic and **NOT COVERED.**

The Plan does not provide coverage for labiaplasty for indications other than gender reassignment or surgical reconstruction following trauma or surgical treatment of disease (e.g., oncological surgery). Other indication for labiaplasty are considered cosmetic and **NOT COVERED**.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Management of Excessive Skin and Subcutaneous Tissue

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

CPT/HCPCS Codes:

15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832 Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh
15833 Excision, excessive skin and subcutaneous tissue (including lipectomy); leg
15834 Excision, excessive skin and subcutaneous tissue (including lipectomy); hip
15835 Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock
15836 Excision, excessive skin and subcutaneous tissue (including lipectomy); arm
15837 Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand
15838 Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad
15839 Excision, excessive skin and subcutaneous tissue (including lipectomy); other area
15847 Excision, excessive skin and subcutaneous tissue (including lipectomy);abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial placation)
15876 Suction assisted lipectomy; head and neck
15877 Suction assisted lipectomy; trunk
15878 Suction assisted lipectomy; upper extremity
15879 Suction assisted lipectomy; lower extremity

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 4/98

Revised: 12/01, 2/03, 2/04 (diastasis exclusion); 2/05, 2/06 (Definitions, coding); 2/07; 10/09 (criteria), 11/15 (Added Indications); 11/16, 11/18 (clarify indications and exclusions); 10/20 (add labiaplasty exclusion)

Reviewed: 3/08; 11/10, 11/11, 11/12, 11/13, 11/14, 10/17, 10/19, 10/21, 10/22, 10/23