

# Panniculectomy and Body Contouring Procedures

**Policy Number:** MP.014.22  
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[Instructions for Use](#)

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## Application

### UnitedHealthcare Commercial

This Medical Policy applies to all UnitedHealthcare Commercial benefit plans.

### UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado.

## Coverage Rationale

### Panniculectomy

**Panniculectomy is considered Reconstructive and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Panniculectomy, Abdominal.

Click [here](#) to view the InterQual® criteria.

**Panniculectomy is not considered medically necessary when performed for the following indications:**

- For any other condition that does not meet the criteria above in this document
- In conjunction with abdominal or gynecologic surgery, including, but not limited to, hernia repair, bariatric surgery, C-section, or hysterectomy, unless the member meets the criteria for Panniculectomy as stated above in this document
- When performed for primarily cosmetic purposes, including but not limited to, post childbirth in order to return to pre-pregnancy shape

### Body Contouring Procedures

**Body contouring procedures, including but not limited to the following, are considered cosmetic and not medically necessary:**

- Abdominoplasty
- Lipectomy, including Suction-Assisted Lipectomy, (unless part of an approved procedure). For post-mastectomy, refer to the Medical Policy titled [Breast Reconstruction](#).
- Repair of Diastasis Recti

Note: For information on liposuction for lipedema, refer to the Medical Policy titled [Liposuction for Lipedema](#).

## Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
<b>Panniculectomy and Body Contouring Procedures</b>	
15830 15847 15877 15878 15879	<p>Medical notes documenting the following, when applicable:</p> <ul style="list-style-type: none"> <li>• Primary complaint, history of complaint, and physical exam, including: <ul style="list-style-type: none"> <li>○ Grade of panniculus</li> <li>○ Body mass index (BMI)</li> <li>○ History of recent weight loss in lbs/kgs</li> <li>○ History of weight stability and duration</li> <li>○ History of dermatologic complications</li> </ul> </li> <li>• Diagnosis of dermatologic complications (e.g., skin infection, ulcers, maceration, skin breakdown, etc.)</li> <li>• Treatments (e.g., antibiotic, corticosteroid, antifungal) for dermatologic complications tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation</li> <li>• Details of functional limitations due to pannus interfering with activities of daily living (ADL)</li> <li>• Relevant surgical history, including dates</li> <li>• Physician treatment plan, including specific and associated procedures</li> <li>• Upon request we may require high-quality color photographs <ul style="list-style-type: none"> <li>○ For panniculectomy, photographs of a full-frontal view of the hanging pannus, a full-frontal view of pannus elevated that allows any skin damage can be evaluated, and a full lateral view of the hanging pannus</li> <li>○ All photographs must be labeled with the date taken and the applicable case number obtained at time of notification, or member’s name and ID number on the photograph(s)</li> <li>○ <b>Note:</b> Submission of color photographs can be submitted via the external portal at <a href="http://www.uhcprovider.com/paan">www.uhcprovider.com/paan</a>; faxes of color photographs will not be accepted</li> </ul> </li> </ul>

\*For code descriptions, refer to the [Applicable Codes](#) section.

## Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable 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 (ASPS, 2017).

**Diastasis Recti:** A vertical abnormal separation of the rectus abdominis muscles (Olsson et al., 2021).

**Functional or Physical or Physiological Impairment:** A Functional or Physical or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions (Medicare, 2023).

**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. A cosmetic Abdominoplasty is sometimes performed at the time of a functional Panniculectomy (ASPS, 2017).

**Suction-Assisted Lipectomy:** Suction-Assisted Lipectomy (SAL), more commonly known as Liposuction, is an outpatient procedure that removes adipose tissue from the subcutaneous space with the goal of achieving a more desirable body contour (Wu et al., 2020)

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
<b>The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.</b>	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	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)
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
<b>The following codes are considered cosmetic; the codes do not improve a functional, physical or physiological impairment.</b>	
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15876	Suction assisted lipectomy; head and neck

*CPT® is a registered trademark of the American Medical Association*

## Description of Services

An abdominal panniculus is an apron of skin and fat that hangs down from the abdomen. This often occurs following massive weight loss and can lead to skin infections, rashes, and difficulty completing activities of daily living (Sachs et al., 2021). A Panniculectomy is a surgery that removes this excess skin and fat but typically does not involve the abdominal muscles (ASPS, 2017).

Body contouring is a collection of procedures to change the shape of the body. Adipose tissue is usually removed, with or without removal of excess skin. Body contouring procedures can be either invasive or nonsurgical.

## Panniculectomy

There is insufficient quality evidence to conclude that panniculectomy in conjunction with abdominal or gynecological surgery, including, but not limited to, hernia repair, bariatric surgery, C-section, or hysterectomy, outweighs negative outcomes. Additional peer-reviewed literature is needed to determine if there are any long-term benefits and that the benefits outweigh the risks when panniculectomy is performed at the same time. Panniculectomy performed post childbirth in order to return to pre-pregnancy shape is considered a cosmetic procedure.

Elhage et al. (2021) evaluated the outcomes and quality of life (QOL) in patients undergoing complex abdominal wall reconstruction (AWR) with panniculectomy utilizing 3D volumetric-based propensity match in a prospective cohort study. A prospective database from a tertiary referral hernia center was queried for patients undergoing open AWR. 3D CT volumetrics were analyzed and a propensity match comparing AWR patients with and without panniculectomy was created including subcutaneous fat volume (SFV). QOL was analyzed using the Carolinas Comfort Scale. Propensity match yielded 312 pairs, all with adequate CT imaging for volumetric analysis. The panniculectomy group had a higher BMI ( $p = 0.03$ ) and were more likely female ( $p < 0.0001$ ), but all other demographics and comorbidities were similar. The panniculectomy group was more likely to have undergone prior hernia repair (77% vs 64%,  $p < 0.001$ ), but hernia area, SFV, and CDC wound class were similar (all  $p > 0.05$ ). Requirement of component separation (61% vs 50%,  $p = 0.01$ ) and mesh excision (44% vs 35%,  $p = 0.02$ ) were higher in the panniculectomy group, but operative time were similar (all  $p \geq 0.05$ ). Panniculectomy patients had a higher overall wound occurrence rate (45% vs 32%,  $p = 0.002$ ) which was differentiated only by a higher rate of wound breakdown (24% vs 14%,  $p = 0.003$ ); all other specific wound complications were equal (all  $p \geq 0.05$ ). Hernia recurrence rates were similar (8% vs 9%,  $p = 0.65$ ) with an average follow-up of 28 months. Overall QOL was equal at 2 weeks, and 1, 6, and 12 months (all  $p \geq 0.05$ ). The authors concluded that despite panniculectomy patients and their hernias being more complex, concomitant panniculectomy increased wound complications but did not negatively impact infection rates or long-term outcomes and recommended concomitant panniculectomy be considered in appropriate patients to avoid two procedures.

In a retrospective cohort study, Gebran et al. (2021) evaluated the risk profile of panniculectomy when performed in select patients at the time of bariatric surgery. The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) database (2016-2017), in which data on 379,544 bariatric surgeries were reported was examined. Concurrent panniculectomy procedures were identified by Current Procedural Technology (CPT) codes. Patient characteristics and in-hospital as well as 30-day complications were compared between the body contouring group and propensity score-matched bariatric surgery controls. One hundred twenty-four patients met inclusion criteria and were matched to 248 controls. An infra-umbilical panniculectomy was performed in the majority of patients ( $n = 94$ , 75.8%). Most patients received an open rather than laparoscopic bariatric surgery ( $n = 87$ , 70.2%). There were no statistically significant differences between 30-day mortality (1.9%), wound complications (11.5%), readmission (12.5%) and reoperation (5.8%) between the 2 groups ( $p > .05$ ). Wound complications occurred in 11.5% of patients and were associated with prolonged hospital stay (odds ratio 4.65, 95% confidence interval 1.99–10.86,  $p < .001$ ) and a body mass index (BMI)  $> 50$  (odds ratio 3.19, 95% confidence interval 1.02–9.96,  $p = .046$ ). The authors concluded, in select patients, panniculectomy at the time of bariatric surgery was not associated with increased in-hospital or 30-day adverse outcomes compared with matched bariatric surgery controls, however, revision surgery may be needed once weight loss stabilizes. The study was limited by database limitations, short-term follow up, and multiple outcome variables.

Nag et al. (2021) performed a retrospective cohort study and systematic review to evaluate the premise that the addition of panniculectomy to gynecologic surgery in the obese and morbidly obese patient population results in a statistically significant improvement in measurable outcomes. The American College of Surgeons National Surgical Quality Improvement Program (NSQIP) database was reviewed to assess the association of complications with panniculectomy combined with gynecologic surgery in the morbidly obese patient population. The query identified 296 patients with a body mass index greater than 30 who had panniculectomy concomitant with gynecologic surgery. The results demonstrated a statistically significant relationship ( $p < 0.05$ ) of these concomitant procedures with superficial infection, wound infection, pulmonary embolism, systemic sepsis, return to operating room, length of operation and length of stay. A systematic review of the literature was then performed which identified only 5 studies that included comparative cohorts of those with gynecologic surgery, with and without panniculectomy. There was no significant benefit across the studies in measured parameters. The authors concluded that there was no statistically significant benefit associated with performing panniculectomy in conjunction with gynecologic surgery in the

morbidly obese patient population and that there was significant elevation of negative outcomes in morbidly obese patients undergoing combined procedures.

In a systematic meta-analysis, Prodromidou et al. (2020) assessed the current knowledge concerning the safety and efficacy of combining panniculectomy in surgical management of endometrial cancer (EC) in obese patients. Four electronic databases were systematically searched for articles published up to May 2019. A total of five studies, of which two were non-comparative and three comparative, were included. Meta-analysis of complications among panniculectomy and conventional laparotomy group revealed no difference in either intra- or post-operative complication rates. Moreover, no difference was reported in surgical site complications ( $p = 0.59$ ), while wound breakdown rates were significantly elevated in the laparotomy group ( $p = 0.02$ ). The authors concluded panniculectomy combined surgery for the management of EC can be considered a safe procedure in selected patients and presents with comparable outcomes to conventional laparotomy procedures with regard to non-surgical and surgical site complications and improved wound breakdown rates. The authors noted that the outcomes must be cautiously interpreted because of the limited number of studies included in this meta-analysis and their retrospective nature.

Sosin et al. (2020) conducted a systematic meta-analysis to assess the durability, complication profile, and safety of simultaneous ventral hernia repair and panniculectomy (SVHRP) through a large data-driven repository of SVHRP cases. The current SVHRP literature was queried using the MEDLINE, PubMed, and Cochrane databases. Predefined selection criteria resulted in 76 relevant titles yielding 16 articles for analysis. Meta-analysis was used to analyze primary outcomes, identified as surgical-site occurrence and hernia recurrence. Secondary outcomes included review of techniques used and systemic complications, which were analyzed with pooled weighted mean analysis from the collected data. There were 917 patients who underwent an SVHRP (mean age,  $52.2 \pm 7.0$  years; mean body mass index,  $36.1 \pm 5.8$  kg/m; mean pannus weight, 3.2 kg). The mean surgical-site occurrence rate was 27.9% (95% CI, 15.6 to 40.2%;  $I = 70.9\%$ ) and the mean hernia recurrence rate was 4.9% (95% CI, 2.4 to 7.3%;  $I = 70.1\%$ ). Mean follow-up was  $17.8 \pm 7.7$  months. The most common complications were superficial surgical-site infection (15.8%) and seroma formation (11.2%). Systemic complications were less common (7.8%), with a thromboembolic event rate of 1.2%. The overall mortality rate was 0.4%. The authors concluded SVHRP is associated with a high rate of surgical-site occurrence, but surgical-site infection seems to be less prominent than previously anticipated. The authors indicated the low hernia recurrence rate and the safety of this procedure support its current implementation in abdominal wall reconstruction. (McNichols et al., 2018 is included in this review)

In a retrospective cohort study, Diaconu et al. (2019) compared outcomes in obese patients who undergo ventral hernia repair with concurrent panniculectomy versus ventral hernia repair alone. Postoperative complications were compared between patient who underwent concurrent panniculectomy and those who did not. A total of 223 patients were analyzed: 122 in the ventral hernia repair with concurrent panniculectomy group and 101 in the ventral hernia repair-only group. Median follow-up duration was 141 days. Patients in the ventral hernia repair with concurrent panniculectomy group had more surgical-site occurrences (57 percent versus 40 percent;  $p = 0.012$ ). Both groups had similar rates of surgical-site occurrences that required an intervention (39 percent versus 31 percent;  $p = 0.179$ ) and similar rates of hernia recurrence (23 percent versus 29 percent;  $p = 0.326$ ). Multivariate analysis showed that concurrent panniculectomy increased the risk of surgical-site occurrences by two-fold; however, it did not increase the risk of surgical-site occurrences that required an intervention. The authors concluded the addition of a panniculectomy to ventral hernia repair increases surgical-site occurrences but does not increase complications that require an intervention.

McNichols et al. (2018) conducted a retrospective case series review of patients from the University of Maryland Medical Center to review the risks and benefits of combined ventral hernia repair and panniculectomy (VHR/PAN). A retrospective database was collected using current procedural terminology codes for VHR/PAN. The patient-specific variables that were studied include the following: sex, body mass index (BMI), smoking, diabetes, chronic obstructive pulmonary disease, cirrhosis, immunosuppression, length of operation, acute incarcerated hernias, hernia size and location, mesh size and location, pannus weight, concomitant component separation, use of negative-pressure wound therapy, intestinal violation, follow-up duration, ventral hernia working group, history of bariatric surgery, previous hernia repair, skin dehiscence, skin necrosis, chronic wound, surgical site infection, seroma, hematoma, fascial dehiscence, hernia recurrence, unplanned return to operating room, and medical complication. Both univariate and multivariate analyses were performed to determine which factors affected the complication outcomes. There were 106 patients with an average age and BMI of 53 years and 39, respectively. Fifty-eight patients (54.72%) had at least 1 surgical site occurrence. Twenty-three patients (21.70%) had at least 1 repair failure. Twenty-eight patients (26.42%) had an unplanned trip back to the operating room. Seventeen patients (16.04%) had at least 1 medical complication. The authors concluded the risk factors associated with developing complications are higher BMI, longer operating time, larger mesh size, larger hernia size, component separation, use of biologic mesh, chronic obstructive

pulmonary disease, and intestinal violation. The use of negative-pressure wound therapy decreased complication rates, and patients with a previous hernia repair seemed to benefit the most from having a combined VHR/PAN. The authors concluded, when compared with previous reports of VHR alone, VHR/PAN does seem to increase wound complications and reoperation rates.

Fennimore et al. (2015) conducted a retrospective cohort study to determine whether a modified abdominal panniculectomy at the time of cesarean delivery decreases wound complications in morbidly obese women. The study included 59 morbidly obese patients who delivered via cesarean section at a single center between 2003 and 2009. A total of 30 morbidly obese patients who underwent modified panniculectomy at the time of cesarean section were compared to a control group of 29 morbidly obese women who underwent cesarean section alone. Of the 30 women who underwent modified panniculectomy at the time of cesarean, 3% (n = 1) developed operative site infection that required readmission. In the control group, 24% (n = 7) developed operative site infection (p = 0.026), and 10% (n = 3) were readmitted (p = 0.35). There was no difference in the postpartum length of hospital stay, intraoperative blood loss, operative time and infant delivery time between the two groups. In the cohort, morbidly obese women who underwent panniculectomy at the time of cesarean section had lower incidence of wound complications without significant increase in operative time, hospital length of stay, and infant delivery time. The authors concluded modified panniculectomy at the time of cesarean may be a useful adjunct in an effort to decrease postoperative infectious morbidity in obese patients, however, the effects of the procedure on long-term healing, future obstetric outcomes, and other medical conditions warrant further evaluation.

## **Clinical Practice Guidelines**

### **American Society of Plastic Surgeons (ASPS)**

ASPS (2019) recommends when an abdominoplasty or panniculectomy are performed solely to enhance a patient's appearance in the absence of any signs or symptoms of functional abnormalities, the procedure should be considered cosmetic in nature and not a compensable procedure unless specified in the patient's policy. ASPS further recommends that a panniculectomy should be considered a reconstructive procedure when performed to correct or relieve structural defects of the abdominal wall, improve skin health within the fold beneath the pannus, and/or help improve chronic low back pain due to functional incompetence of the anterior abdominal wall. In rare circumstances, plastic surgeons may perform a hernia repair in conjunction with an abdominoplasty or panniculectomy. A true hernia repair involves opening fascia and/or dissection of a hernia sac with return of intraperitoneal contents back to the peritoneal cavity. A true hernia repair should not be confused with diastasis recti repair, which is often part of a standard abdominoplasty.

In a practice parameter, ASPS (2017) noted panniculectomy could be considered as a functional correction in patients who are of appropriate height and weight, and have a history of problems including panniculitis or chronic back pain that have persisted despite an adequate trial of non-surgical management, or have a functional impairment in activities of daily living/work, etc. ASPS notes a strong relationship between increased BMI and surgical complication across the surgical spectrum. Acarturk et al. (2004) retrospectively compared the surgical outcomes of 21 patients that had simultaneous panniculectomy and bariatric surgery to 102 patients that delayed panniculectomy following bariatric surgery by a mean of 17 months. Those who had simultaneous surgery had significantly more complications and higher mortality.

### **Society of Obstetricians and Gynaecologists of Canada (SOGC)**

SOGC clinical practice guideline for gynecologic surgery for patients with obesity (Yong et al., 2019) reviews the evidence for panniculectomy performed concurrently with gynecologic surgeries. The guideline notes that studies in this area have been primarily small, retrospective, and/or non-comparative studies. The authors indicated that panniculectomy can be considered at the time of open hysterectomy in patients with obesity, although it is rarely performed; and when a combined procedure is done, consideration should be given to postoperative antibiotics.

## **Body Contouring**

Body contouring procedures are typically performed for cosmetic purposes. Body contouring procedures can include, but are not limited to, abdominoplasty, lipectomy, and body lifts. Procedures are often combined for a more global aesthetic improvement (Shermak, 2020).

In a retrospective case study, Ibrahiem (2022) assessed a comparison of operative risk, hospital length of stay, complication rate, and patient satisfaction in massive weight loss patients (MWLP) according to the number of surgical procedures

performed in the same surgical setting. The study included 653 MWLP who underwent multiple contouring procedures simultaneously in a single surgical procedure. All patients underwent surgery between 2016 and 2020. The patients studied were divided into 4 groups according to the number of anatomical areas operated on. A total of 1254 body contouring procedures were included in the study with a mean of 17 months. The study found that the number of blood transfusions were statically significantly higher in the IV group (22 patients) than in the other three groups ( $p$  value = 0.001). There were no blood transfusions in groups I and II. In comparison to other studies, the average hospital stay was 1.25 days. The overall complication rate (major and minor) was 105 cases (16.07%) in all groups. Patient satisfaction was highest in patients who underwent 2-3 procedures within the same surgical setting compared to patients who underwent + 3 procedures. The author concluded performing 2 to 3 combined cosmetic procedures in the same surgical setting did not significantly increase the overall complication rates in the study, but four or more combined procedures were associated with an increase in the complication rate.

Kalmar et al. (2022) performed a retrospective cohort study to determine whether certain complications are more likely to occur in patients undergoing functional panniculectomy versus cosmetic abdominoplasty. The study included a total of 11,137 patients who underwent excision of excessive infraumbilical abdominal skin, either a functional panniculectomy ( $n = 6397$ ) or cosmetic abdominoplasty ( $n = 4740$ ). Patients undergoing functional panniculectomy were significantly more likely to have comorbidities than those undergoing cosmetic abdominoplasty ( $p < .001$ ). Overall adverse events ( $p < .001$ ), medical complications ( $p = .047$ ), surgical complications ( $p < .001$ ), related readmission ( $p < .001$ ), and related reoperation ( $p < .001$ ) were significantly higher in patients undergoing functional panniculectomy. Surgical complications significantly higher in functional panniculectomy included superficial incisional infection ( $p < .001$ ), deep incisional infection ( $p < .001$ ), organ/space infection ( $p < .001$ ), dehiscence ( $p = .003$ ), and bleeding requiring transfusion ( $p = .003$ ). The researchers concluded functional panniculectomy have increased risk of superficial incisional infection, deep incisional infection, organ/space infection, dehiscence, bleeding requiring transfusion, and sepsis compared to patients undergoing cosmetic abdominoplasty. These adverse events are associated with specific preoperative comorbidities in these patients.

In a systematic review, Van Kerckhoven et al. (2021) evaluated the treatment of diastasis recti. After inclusion criteria was met 24 articles were reviewed. Patients ( $n = 931$ ) with rectus diastasis were studied with a follow-up period from 3 weeks to 20 years. Treatment techniques included rectus sheath plication ( $n = 761$ ) and midline mesh reinforcement ( $n = 170$ ). The most frequently noted comorbidity was obesity and 10.6 percent were smokers. Recurrence was reported in 5 percent of the patients. The most frequent complication was seroma (7%), followed by abdominal hypoesthesia (6%), and surgical site infection (2%). Chronic pain was reported in 4 percent of the patients. Satisfaction was assessed subjectively in the majority of patients and was generally rated as high. The authors concluded treatment of diastasis recti is reliable and long-lasting but could not identify which treatment technique was more reliable.

Jiang et al. (2021) noted many post-bariatric patients have impaired health-related quality of life (HRQoL) due to excess skin following weight loss; however, it is inconclusive whether body contouring surgery (BCS) improves this impairment. In a systematic review, the authors summarized existing evidence of the effect of BCS on HRQoL and determine the prevalence of, the desire for, and barriers to BCS (secondary outcomes). Randomized controlled trials, cohort, cross-sectional, case-control, and longitudinal studies were systematically searched in PubMed, Embase, the Cochrane Central, and Web of Science. After screening 1923 potential records, 24 studies (representing 6867 participants) were deemed eligible. Only 18.5% of respondents from cross-sectional studies underwent BCS, with abdominal BCS as the most common procedure. Most participants desired BCS but listed "cost" and "lacking reimbursement" as the main barriers. The authors concluded the results suggest that most post-bariatric patients who underwent BCS experienced improvements in their HRQoL, which could be seen in almost every dimension evaluated, including body image and physical and psychosocial functions. The authors recommended both bariatric and plastic surgeons should regard BCS not only as an aesthetic supplement but also as a vital part of functional recovery in the surgery-mediated weight loss journey and, thus, provide it to more post-bariatric patients.

Olsson et al. (2021) performed a systematic review to analyze the outcomes of rectus diastasis (RD) repair, focusing on functional changes following surgery. A comprehensive search in PubMed and Web of Science was performed. Suitable papers were selected using titles and abstracts with terms suggesting surgical treatment of RD. All abstracts were scrutinized, and irrelevant studies excluded in four stages. Reports providing original data, including outcome assessment following surgery, were included. Ten papers with a total of 780 patients were found to fulfil the search criteria. Study design, surgical procedure, follow-up time, functional outcome and assessment instruments were compiled. All included studies reported improvements in a variety of functional aspects regardless of surgical method. The outcomes assessed include core stability, back pain, abdominal pain, posture, urinary incontinence, abdominal muscle strength and quality of life. The authors concluded that the

review showed surgical repair of RD is a safe and effective treatment that improves functional disability, however, the absence of standardized instruments for assessing outcome makes it impossible to compare studies. Since indications for surgery are relative and related to core function, the authors recommended valid instruments for assessing indication and outcome are needed to ensure benefit of the procedure. The study was limited by the number of studies included in the review and a low level of evidence in some of the included studies.

In a systematic review, Gormley et al. (2020) reviewed the effect of rectus plication on abdominal strength, function, and postoperative complications. A comprehensive search of CINAHL, Embase, Medline and Web of Science was performed. Screening and data extraction were performed in duplicate. Data were extracted from the included articles, and outcomes were analyzed categorically. A total of 497 patients from seven articles were included. Mean age was 44.5 years (range 20.5-72) and 94.4% were female. Three articles reported abdominal strength measurements, with two showing significant improvement. Four articles used the SF-36 survey, all demonstrating improvement in physical function subscale postoperatively. An additional six instruments were used to assess functional outcomes, of which four demonstrated significant improvement. The overall complication rate was 17.0%. The authors noted rectus plication is commonly performed during abdominoplasty to improve abdominal form and function. They concluded that while the literature to date is encouraging with respect to functional outcomes, improvements in abdominal strength are less consistent. Heterogeneity in patient population, outcome measures, and comparison groups limit the strength of the authors' conclusions. The authors recommend future research should include a large comparative study as well as a protocol for standardizing outcomes in this population.

Wu et al. (2020) note liposuction is the second most commonly performed cosmetic surgery in the United States. Suction-assisted lipectomy, more commonly known as liposuction, is an outpatient procedure that removes adipose tissue from the subcutaneous space with the goal of achieving a more desirable body contour. It is the second most commonly performed cosmetic surgery in the United States and the most common surgical procedure in patients between the ages of 35 and 64. Liposuction is used to achieve body contouring by removing excess fat deposits in undesirable areas of the body. Fat is suctioned from demarcated areas in the body amenable to contouring. Liposuction is also increasingly being used as an adjunct to enhance other aesthetic procedures such as breast augmentation, cervicoplasty, abdominoplasty, gluteal fat transfer, and body contouring for postsurgical bariatric patients. Non cosmetic indications are expanding, particularly fat grafting for breast, facial, and pedal reconstruction.

Akram et al. (2014) investigated indications for surgical repair of RD in a systematic review. The authors presented classifications of RD, current knowledge on the relation to pregnancy, and conservative and surgical management. A systematic search in PubMed, Embase, Cochrane, and CINAHL revealed 437 studies. Inclusion criteria were applied according to the above mentioned subjects of interest. In total 28 studies were included, representing 3725 patients, 11 of these by assessing reference lists of included studies. Only one RCT was found; most studies were case series lacking statistical analysis. RD was common in post-partum women. Antepartum activity level may have a protective effect on RD and exercise may improve post-partum symptoms of RD. Repair was done during abdominoplasty or laparoscopically. The patient-satisfaction was high and long-term recurrence was reported by one study, while five reported no recurrence. Overall major complications were few, while minor complications were primarily seroma and wound complications. RD is by itself not a true hernia and, therefore, not associated with the risk of strangulation. The authors conclusions included repair is mostly done due to cosmetic reasons, the condition does not necessarily require repair, and conservative management may be an alternative. The authors further note that, if done, the protrusion of the abdomen, rather than the diastasis itself should influence the decision of repair. The authors recommended that future studies use the established classifications (e.g. Beer, Rath, or Nahas) when reporting RD and long-term outcome of treatment. Comparison of surgical techniques and studies that address and compare conservative management with surgery are needed.

Staalesen et al. (2012) performed a systematic review to evaluate the quality of evidence of benefits and risks for patients having abdominoplasty from massive weight loss or childbirth. Outcome measures were quality-of-life, respiratory function, back pain, and complication rates. PubMed, Cochrane Database of Systematic Reviews, CRD, CINDAHL, AMED, PsycINFO and different Health technology Assessment organizations (SBU, Kunnskapssenteret, Sundhetsstyrelsen) were searched for articles published until October 2011. Inclusion criteria were studies written in English or Scandinavian language including at least 30 patients with a control group and a case series of at least 100 patients. Review articles and case studies were excluded. The scientific level of evidence was evaluated using the GRADE-system. One small, controlled study on abdominoplasty was found indicating a positive effect on quality-of-life. No controlled studies evaluating the other outcomes respiratory function and back pain were found. One prospective study reported minor complications averaging to 25%. Fourteen retrospective studies reported the same pattern. The major complication venous thromboembolism was found in 2%-



8% in three series. The authors concluded that the quality of evidence of positive health effects for patients having abdominoplasty is very low concerning all studied outcomes.

## **Clinical Practice Guidelines**

### **American Society of Plastic Surgeons (ASPS)**

ASPS (2016) states abdominoplasties are typically performed for purely cosmetic indications such as unacceptable appearance due to fat maldistribution or contour deformities caused by pregnancy, stretch marks, contracted scars, and loose hanging skin after weight loss.

In a practice parameter, ASPS (2017) indicates the timing for body contouring surgery is ideally performed after the patient maintains a stable weight for 2 to 6 months. For post bariatric surgery patients, this often occurs 12-18 months after surgery or at the 25 kg/mg<sup>2</sup> to 30 kg/mg<sup>2</sup> weight range. Sometimes procedures are staged. An initial functional panniculectomy with limited tissue undermining and/or reduction mammoplasty may be necessary to increase the patient's comfort and facilitate the ease of exercise and further weight loss. Once the patient approaches his/her ideal body weight more refined body contouring surgery may be performed to address aesthetic issues.

ASPS (2017) indicates deformities associated with massive weight loss vary greatly depending on the patients' body type, their fat deposition pattern, and the amount of weight gained or lost. These deformities can lead to patient dissatisfaction with appearance, inability to exercise, impaired ambulation, chronic back, neck and shoulder pain, difficulty with hygiene and symptoms such as uncontrolled intertrigo, infections, and skin necrosis. A panniculectomy or abdominoplasty alone will eliminate the large hanging abdominal panniculus and its associated symptomatology, but may leave redundant tissue known as "dog ears" posterior to the excision. Circumferential approaches such as belt lipectomy, and circumferential lipectomy provide a superior aesthetic result because the anterior deformities as well as back and side rolls are addressed, and the buttocks lifted. Abdominoplasty and circumferential lipectomy typically would be considered cosmetic procedures.

## **U.S. Food and Drug Administration (FDA)**

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Panniculectomy and body contouring procedures are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information: <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed February 22, 2023)

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## Policy History/Revision Information

Date	Summary of Changes
03/01/2024	<p><b>Related Policies</b></p> <ul style="list-style-type: none"> <li>Updated reference link to reflect current policy title for <i>Gender Dysphoria Treatment</i></li> </ul>
10/01/2023	<p><b>Application</b></p> <p><b>Individual Exchange Plans</b></p> <ul style="list-style-type: none"> <li>Removed language indicating this Medical Policy does not apply to Individual Exchange benefit plans in the states of Massachusetts, Nevada, and New York</li> </ul>

Date	Summary of Changes
	<p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Archived previous policy version MP.014.21</li> </ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual<sup>®</sup> criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.