NO. 91444

PANNICULECTOMY/ABDOMINOPLASTY

Effective: 09/01/2026
Committee Review: 08/2026
Last Updated: 08/2026

Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This policy outlines when panniculectomy is medically necessary under InterQual® criteria and clarifies that abdominoplasty is generally considered cosmetic unless there is functional impairment. It also specifies situations in which both procedures are deemed cosmetic, investigational, or not medically necessary

Related policies:

- Cosmetic and Reconstructive Surgery Procedures - 91535

I. MEDICAL NECESSITY CRITERIA

A. Panniculectomy may be medically necessary when applicable InterQual® criteria are met.

B. Abdominoplasty is considered cosmetic and not medically necessary unless abdominal wall laxity interferes with activities of daily living and causes a functional impairment.

1. Priority Health considers abdominoplasty to be experimental, investigational, unproven, or not medically necessary for all other indications, including, but not limited to:
    a. Minimization of the risk of hernia formation or recurrence is experimental, investigational, or unproven.

b. For the sole purpose of treating neck or back pain is experimental, investigational, or unproven.
c. Repair of diastasis recti (defined as a thinning out of the anterior abdominal wall fascia) is not medically necessary.
d. When performed in conjunction with abdominal or gynecological procedures such as but not limited to abdominal hernia repair (i.e., incisional/ventral, epigastric or umbilical), hysterectomy, obesity surgery is not medically necessary.
e. When performed solely to enhance a member's appearance in the absence of any signs or symptoms of functional abnormalities is considered cosmetic.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	LCD L39506 – Cosmetic and Reconstructive Surgery
First Coast Service Options, Inc.	None identified
Wellpoint federal (formerly National Government Services, Inc.)	None identified
Noridian Healthcare Solutions	None identified
Novitas Solutions, Inc.	LCD L35090 – Cosmetic and Reconstructive Surgery
Palmetto GBA	LCD L33428 – Cosmetic and Reconstructive Surgery
WPS Insurance Corporation	LCD L39051 – Cosmetic and Reconstructive Surgery

III. BACKGROUND

In the United States, the 2020 National Health and Nutrition Examination Survey found that over 40% of the U.S. population was obese—a potential underestimation of current indexes. Furthermore, studies predict that over half of the population is expected to be

obese by 2030. Although no panacea exists in addressing obesity, a healthy lifestyle, weight loss surgery, and pharmacologic interventions have demonstrated success. Irrespective of modality, massive weight loss presents its own set of challenges, not least of which is redundant skin. (Laspro et al., 2024)

Abdominoplasty is a procedure involving the removal of excess abdominal skin and/or fat with or without tightening lax anterior abdominal wall musculature. This recontouring of the abdominal wall area is often performed solely to improve the appearance of a protuberant abdomen by creating a flatter, firmer abdomen. The standard abdominoplasty involves plication of the anterior rectus sheath for muscle diastasis (i.e., repair of diastasis recti) and removal of excess fat and skin. Traditional abdominoplasty can be performed as an open procedure or endoscopically. Abdominoplasty completed by endoscopic guidance is usually reserved for those patients who seek less extensive contouring of the abdominal wall. Mini-abdominoplasty, with or without liposuction, is a partial abdominoplasty involving the incision of the lower abdomen only. The procedure is generally performed solely for cosmetic purposes to improve the appearance of the abdominal area. The procedure ranked as the fourth most common surgical procedure in 2018 with over 100,000 performed cases according to the International Society of Aesthetic Plastic Surgery (ISAPS) (Lim et al., 2024)

Reduction in abdominal adiposity may result in an overhanging pannus. Panniculectomy is the surgical procedure that removes excess skin and body fat from the lower abdomen on patients suffering from obesity or who have had a significant weight loss. This excess skin and fat is called the abdominal pannus or panniculus, often referred to as an apron. A large hanging panniculus can cause problems such as intertrigo (a form of superficial dermatitis), intertriginous dermatitis, cellulitis, tissue necrosis or ulceration, or panniculitis (painful inflammation of the subcutaneous adipose tissue). It can also interfere with patients' ability to ambulate, exercise, and find properly fitting clothes. Obesity is a predisposing factor for panniculitis. When panniculitis is severe, it may interfere with activities of daily living, such as personal hygiene and ambulation. The demand for panniculectomy has increased as patients have had successful weight loss after gastric bypass surgical procedures. It has been proposed that performing abdominoplasty or panniculectomy in the same operative session as abdominal or gynecological surgeries may facilitate surgical access or promote postoperative wound healing and minimize the potential for wound complications, however, there is insufficient evidence in the published, peer-reviewed scientific literature to support such assertions. Priority Health utilizes InterQual® Procedures criteria for the prior authorization of panniculectomy. InterQual criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included PubMed, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have been used. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a

dose-response and the likely effect of plausible confounders. (Source: Change Healthcare LLC).

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Society of Plastic Surgeons (ASPS)	Abdominoplasty and Panniculectomy – Performance Measurement Set (2017)
American Society of Plastic Surgeons (ASPS)	Practice Parameter for Surgical Treatment of Skin Redundancy in Obese and Massive Weight Loss Patients (2017)

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice date

VI. CODING

ICD-10 Codes that may support medical necessity
Not specified – see criteria

CPT/HCPCS Codes

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)

Not Medically Necessary

15877 Suction assist lipectomy, trunk

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

To access InterQual guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

To access TurningPoint guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

To access EviCore, InterQual, or TurningPoint guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

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SUMMARY OF CHANGES

Clarifications:

- Panniculectomy is considered medically necessary when applicable InterQual® criteria are met. Abdominoplasty is considered medically necessary when applicable Priority Health criteria are met.

Past committee review dates: 8/01, 12/01, 4/02, 4/03, 12/03, 3/04, 3/05, 2/06, 2/07, 7/07, 2/08, 2/09, 2/10, 8/10, 8/11, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 11/19, 11/20, 11/21, 11/22, 5/23, 5/24, 5/25, 5/26, 8/26

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