

**Mountain State Blue Cross Blue Shield
(Otherwise referred to as the Plan)**

CORPORATE POLICY AND PROCEDURES

TITLE: ABDOMINOPLASTY AND PANNICULECTOMY

No: MP 16

Supersedes No.: N/A

Original Effective Date: 6/11/03

Standards:

Date of Last Review: 8/20/04

Related Policies:

Date of Last Revision: 8/6/04

Page 1 of 4

DRAFT ()

INTERIM ()

FINAL (X)

Lines of Business:

Applies To: FEP (X) PPO (X) POS (X) INDEMNITY (X)

Variation for: (N/A)

Intended Distribution: Standard List (X) Secondary Review List () Secondary Distribution List:()

DESCRIPTION

Abdominoplasty is a surgical procedure which tightens a lax anterior abdominal wall caused by diastasis recti (the separation of the two rectus muscles along the medial line of the abdominal wall) and removes excess fat and abdominal skin. This procedure, also referred to as a “Tummy Tuck”, reduces the protruding abdomen and provides an overall improvement in the person’s shape and figure.

Panniculectomy/abdominal lipectomy is the surgical resection of the overhanging “apron” of redundant skin and fat in the lower abdominal area. A panniculus is often seen in men or women who have had significant weight loss or in morbidly obese patients.

**Mountain State Blue Cross Blue Shield
(Otherwise referred to as the Plan)**

CORPORATE POLICY AND PROCEDURES

TITLE: ABDOMINOPLASTY AND PANNICULECTOMY

No: MP 16

Page 2 of 4

POLICY

Covered Services

Panniculectomy/abdominal lipectomy (initial surgery only) may be considered medically necessary for patients who meet *all* of the following indications:

- In patients with stable weight for at least six (6) months for any of the following:
 - i. Recurrent documented rashes that do not respond to conventional treatment.*
 - ii. Recurrent or non-healing documented ulcers that do not respond to conventional treatment.*
 - iii. When there is a functional impairment, such as significant difficulty with walking.
- Prior six (6) months of documented treatment substantiating the above should be provided by the subscriber's physician, and should include photographs.
- When the panniculus hangs to or below the level of the pubis.
- If the patient has had bariatric surgery, he/she is at least 18 months postoperative.

*Conventional treatment may be defined as treatment with oral antibiotics, topical anti-infective medications and adequate hygiene.

Non-Covered Services

- Abdominoplasty is cosmetic, considered NOT MEDICALLY NECESSARY, and therefore, is ineligible for coverage.

**Mountain State Blue Cross Blue Shield
(Otherwise referred to as the Plan)**

CORPORATE POLICY AND PROCEDURES

TITLE: ABDOMINOPLASTY AND PANNICULECTOMY

No: MP 16

Page 3 of 4

CODES

<u>Code</u>	<u>Number</u>	<u>Description</u>
CPT	15831	Excision, excessive skin and subcutaneous Tissue (including lipectomy); abdomen (Abdominoplasty)
CPT	15877	Suction assisted lipectomy, trunk

REFERENCES:

1. Blue Cross and Blue Shield of North Carolina, SUR6170
2. Blue Cross and Blue Shield of New York, 7.01.53
3. Anthem Blue Cross and Blue Shield, SURG.00048
4. Highmark Policy S-28

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Medical policies are designed to supplement the terms of a member's contract. The member's contract defines the benefits available; therefore, medical policies should not be construed as overriding specific contract language. In the event of conflict, the contract shall govern.

Medical policies do not constitute medical advice, nor the practice of medicine. Rather, such policies are intended only to establish general guidelines for coverage and reimbursement under Mountain State Blue Cross Blue Shield plans. Application of a medical policy to determine coverage in an individual instance is not intended and shall not be construed to supercede the professional judgment of a treating provider. In all situations, the treating provider must use his/her professional judgment to provide care he/she believes to be in the best interest of the patient, and the provider and patient remain responsible for all treatment decisions.

Mountain State Blue Cross Blue Shield (MSBCBS) retains the right to review and update its medical policy guidelines at its sole discretion. These guidelines are the proprietary information of MSBCBS. Any sale, copying or dissemination of the medical policies is prohibited; however, limited copying of medical policies is permitted for individual use.

**Mountain State Blue Cross Blue Shield
(Otherwise referred to as the Plan)**

CORPORATE POLICY AND PROCEDURES

TITLE: ABDOMINOPLASTY AND PANNICULECTOMY

No: MP 16

Page 4 of 4

SIGNATURE PAGE

Approval: _____

Approval: _____

Title: _____

Title: _____

Date: _____

Date: _____