# MEDICAL POLICY

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| **Medical Policy Title** | **Abdominoplasty, Panniculectomy, and Lipedema Reduction Surgery** |
| **Policy Number** | **7.01.53** |
| **Current Effective Date** | **May 21, 2026** |
| **Next Review Date** | **May 2027** |

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

## POLICY STATEMENT(S)

Abdominoplasty

I. An abdominoplasty (tummy tuck) including umbilical transposition and fascial plication for repair diastasis recti, or belt lipectomy (lower body lift) is considered cosmetic and, therefore, is **not medically necessary** for all indications.

Panniculectomy

II. A panniculectomy is considered **medically appropriate** when **ALL** of the following criteria are met:

A. The panniculus is Grade 2 or higher (covering the genitals and upper thigh crease), documented by photographs;

B. A clinically significant skin integrity-related functional impairment resulting from a documented recurrent or persistent medical condition directly related to excess tissue and skin folds of the pannus (e.g., intertrigo, dermatitis, cellulitis, panniculitis, ulceration, or necrosis) which is **both**:

1. Documented by color photographs;

2. Refractory to at least three (3) months of prescribed standard medical management with documented adherence to **both** of the following:

a. Hygiene practices and applicable wound care; **and**

b. Systemic antibiotics, antifungal agents, or corticosteroids;

C. There is a documented expectation that surgery will improve or resolve the significant skin integrity-related functional impairment;

D. If the member has had significant weight loss, medical records must document **either** of the following:

1. For weight loss as a result of bariatric surgery, **all** of the following must be met:

a. A minimum of 18 months has elapsed from the date of the bariatric surgery;

b. Stable weight has been maintained for at least six (6) months prior to the consultation for panniculectomy; **and**

c. Post-operative weight loss is documented by **one (1)** of the following:

i. Body mass index (BMI) is less than or equal to 30 $kg/m^2$;

ii. Percentage of excess weight loss (%EWL) greater than or equal to 40%, calculated from the documented pre-intervention weight; **or**

iii. At least a 100-pound weight loss; **or**

2. For weight loss not related to bariatric surgery, **both** of the following must be met:

a. BMI is less than or equal to 30 $kg/m^2$; **and**

b. Stable weight has been maintained for at least six (6) months prior to the consultation for panniculectomy.

III. A panniculectomy is considered **not medically necessary** for all other indications, including but not limited to:

A. Improving appearance or self-esteem;

B. Correction for poorly fitting clothes or problems with hygiene;

C. Treatment of superficial inflammation or infection when controlled only with topical medications;

D. Treatment of neck or back pain;

E. When performed as an adjunct to other medically necessary abdominal or gynecological surgery (e.g., ventral hernia repair, bariatric surgery, hysterectomy, pelvic procedures), unless panniculectomy criteria are met separately.

Lipedema Reduction Surgery

IV. Lipectomy or liposuction for the treatment of lipedema is considered **medically appropriate** when **ALL** of the following criteria are met:

A. Documented diagnosis of lipedema established by clinical history and physical examination, supported by **all** of the following:

1. Palpable nodules in the adipose tissue;

2. Bilateral, symmetric excess adipose tissue deposition in the extremities;

3. Absence of pitting edema;

4. Easy bruising;

5. Pressure induced pain or tenderness to palpation at affected areas **and**

6. Negative Stemmer sign;

B. Lipedema results in **either** of the following:

1. A clinically significant physical functional deficit (e.g., difficulty ambulating or performing activities of daily living); **or**
2. A documented medical complication (e.g., recurrent cellulitis);

C. Signs and symptoms have not responded to at least six (6) consecutive months of optimal conservative medical management (e.g., weight loss, exercise compression garment/devices, and manual lymphatic drainage);

D. The post-operative treatment plan includes use of compression garments as instructed and continuation of conservative treatment, to maintain benefits, including weight management.

V. Lipectomy or liposuction is considered cosmetic and **not medically necessary** when performed solely for the removal of excess adipose tissue in the absence of a documented functional deficit. However, lipectomy may be an integral part of other covered services.

## RELATED POLICIES

Corporate Medical Policy

7.01.11 Cosmetic and Reconstructive Procedures

## POLICY GUIDELINE(S)

I. Preoperative photographs are an absolute requirement for determination of medical appropriateness.

II. Documentation of functional impairment(s) (e.g., inability to perform activities of daily living), all prescribed standard medical management, and weight trends can be documented by any of the member's treating providers, including but not limited to the performing surgeon, primary care physician, and/or specialist (e.g., wound care, dermatology).

III. The criteria for panniculectomy apply regardless of the cause of the excess fatty tissue or redundant skin. These criteria apply to removal of fatty tissue or redundant (excessive) skin caused by obesity and apply to weight loss due to any reason, including bariatric surgery.

IV. A panniculectomy is ideally performed after the patient maintains a stable weight for two (2) to six (6) months. For post-bariatric surgery patients, this often occurs 12-18 months after surgery or at the 25 $kg/m^2$ to 30 $kg/m^2$ weight range (ASPS 2017).

V. The American Society of Plastic Surgeons' (2017) grading system for the severity of abdominal deformities is as follows:

Grade 1: Panniculus covers hairline and mons pubis but not the genitals

Grade 2: Panniculus covers genitals and upper thigh crease

Grade 3: Panniculus covers upper thigh

Grade 4: Panniculus covers mid-thigh

Grade 5: Panniculus covers knees and below

## DESCRIPTION

The American Society of Plastic Surgeons (2017) defines the following:

Abdominoplasty (“tummy tuck”) is a procedure typically performed for cosmetic purposes, involving the removal of excess skin and fat from the pubis to the umbilicus or above, and may include fascial plication of rectus muscle diastasis and neoumbilicoplasty.

Circumferential lipectomy (also known as belt lipectomy or lower body lift) combines the elements of an abdominoplasty or panniculectomy with removal of excess skin and fat from the lateral thighs and buttocks. The procedure removes a "belt" of tissue from around the circumference of the lower trunk, eliminating lower back rolls and providing elevation of the outer thighs, buttocks, and mons pubis. It may include suction-assisted lipectomy where necessary.

Panniculectomy involves the removal of a hanging pannus of excess skin and fat in a transverse or vertical wedge but does not include muscle plication, neoumbilicoplasty, or flap elevation. Unlike abdominoplasty, panniculectomy does not involve abdominal muscle tightening. Deformities associated with massive weight loss vary depending on body type, fat deposition pattern, and the amount of weight gained or lost. These deformities can lead to inability to exercise, impaired ambulation, chronic back, neck, and shoulder pain, difficulty with hygiene, and symptoms such as uncontrolled intertrigo, infections, and skin necrosis.

Lipedema

Lipedema is a chronic, progressive disorder characterized by abnormal distribution of subcutaneous adipose tissue, accompanied by pain or discomfort in affected areas. It predominantly affects women, often with a family history, and is frequently misdiagnosed as obesity or lymphedema. Lipedema typically presents with bilateral, disproportionate fat accumulation in the extremities (including the hips, buttocks, legs, and thighs), characteristically sparing the hands and feet. The arms may also be affected without edema of the hands. The presence of a nodular or fibrotic texture is palpable in affected areas.

Symptoms include heaviness, pain with pressure, easy bruising, loss of strength, and reduced daily activity levels that significantly affect health and quality of life. The excessive fat deposits are typically unresponsive to diet, exercise, or bariatric surgery. Lipedema typically presents with a negative Stemmer sign (ability to pinch the dorsal skin of the second toe), which helps distinguish it from lymphedema. However, a positive Stemmer sign does not rule out lipedema and likely indicates concomitant lymphedema (termed "lipo-lymphedema").

Untreated lipedema may result in secondary problems, including osteoarthritis and reduced mobility. Over time, the weight of excessive fat can impair the ability to walk. Initially, the lymphatic system can manage the increased interstitial fluid, but in later stages, secondary lymphedema (lipo-lymphedema) can occur if the fatty deposits compromise lymphatic function.

There is no cure for lipedema. The goal of therapy is to reduce symptoms, disability, and functional limitations and to prevent disease progression. Conservative treatment includes manual lymphatic drainage, compression garments, intermittent pneumatic compression, skin care, and exercise. Individuals with lipedema may have obesity as a comorbidity, and dietary guidance is frequently

prescribed. Conservative care may alleviate symptoms, but benefits are often short-lived and may require repeat treatment. For individuals who do not respond to conservative treatment, liposuction may be recommended.

## SUPPORTIVE LITERATURE

Badran et al (2023) performed a dose-response meta-analysis of 22 studies (n=493) evaluating metabolic changes after surgical fat removal (SFR). Peak metabolic benefits at day 50 included reductions in body mass index (2 units), fat mass (3 kilograms), waist circumference (5 centimeters), serum leptin (15 µg/L), tumor necrosis factor-alpha (TNF-a; 0.75 pg/mL), total cholesterol (0.25 mmol/L), and blood pressure (3.5 mmHg systolic/diastolic), but most returned to baseline by day 180. Only insulin sensitivity showed sustained improvement beyond 6 months, with maximum reductions in fasting insulin (17 pmol/L) and Homeostatic Model Assessment for Insulin Resistance (HOMA-IR; 1 point) at day 180. No significant changes were observed in lean body mass, serum adiponectin, resistin, interleukin-6, C-reactive protein, triglycerides, low-density lipoproteins, free fatty acids, or fasting blood glucose. Key limitations include the small number of eligible studies with small sample sizes and heterogeneity introduced by pooling different SFR types (abdominoplasty vs. liposuction), which have dissimilar physiological effects on metabolic parameters. The authors recommended well-designed prospective studies to evaluate metabolic changes and safety beyond 6 months.

Liposuction for Lipedema

In 2021, a Delphi-based consensus on the standard of care for lipedema in the United States was created by a panel of 21 lipedema experts (Herbst 2021). According to the panel, lipedema reduction surgery is currently the only available technique for removing abnormal lipedema tissue (e.g., adipocytes, nodules, fibrotic extracellular matrix, and other non-adipocyte components). It is also the only treatment that slows progression of lipedema and ideally would be performed before complications and disabilities from lipedema develop. The panel found that lipedema reduction surgery significantly improves symptoms, mobility, stance, gait, valgus rotation/deformity of the knee and ankle, quality of life, and redistributes and restores the plantar arch. It also improves lymphatic symptoms, reducing the need for compression and manual therapy and improves lymphatic function as shown by radionucleotide lymphangioscintigraphy.

- Grade A consensus recommendations include that lipedema should be regarded as an LCT disease versus a disease of just adipocytes (fat); lipedema has a distinct distribution of pathologic tissue that differs from non-lipedema obesity.
- Grade B consensus recommendations include that lipedema LCT can affect the abdomen; lipedema tissue is resistant to reduction by diet, exercise, or bariatric surgery; rice-grain, pearl-sized or larger nodules in LCT should be part of the diagnostic criteria for lipedema; lipedema tissue is frequently painful especially when touched.
- Grade C consensus recommendations include that standard conservative therapy for lipedema includes nutritional guidance, manual therapy, compression garments, pneumatic compression device (external pump), and home exercise.

Mortada et al (2024) performed a systematic review and meta-analysis of 20 prospective cohort studies (n=1,785 patients) assessing liposuction for lipedema. The majority of patients were stage 2 or 3, with tumescent liposuction being the most common technique (81%). Meta-analysis of nine studies revealed significant improvements in quality of life, pain, pressure sensitivity, bruising, cosmetic impairment, heaviness, walking difficulty, and itching (all p<.0001). Severe complications were rare, with no instances of shock, recurrence, or mortality. Mean follow-up was 15 months (range 1–96 months). Limitations included the absence of controlled trials, potential publication bias from prospective cohort designs, and limited generalizability, as 70% of studies originated from Germany. The authors concluded that liposuction, especially the tumescent technique, is effective in treating lipedema, enhancing outcomes across different modalities.

Fijany et al (2024) performed a meta-analysis of 10 studies encompassing 2,542 procedures on 906 patients, evaluating traditional tumescent liposuction (TTL), power-assisted liposuction (PAL), and water-assisted liposuction (WAL). All techniques showed significant improvements in pain, bruising, edema, tension, pressure sensitivity, and cosmetic and general impairment (all p<0.00001). Overall complication rates were low: TTL 1.5%, PAL 4.0%, WAL 0%, and combined PAL/WAL at 2.3%. Limitations included high heterogeneity for some outcomes and only one study using WAL exclusively, restricting definitive conclusions about technique superiority. The authors concluded that while all techniques are effective, further comparative studies are needed to establish optimal surgical approaches.

Kruppa et al (2026) published a Delphi consensus study in which experts from 19 countries reached consensus on 59 statements regarding the definition and management of lipedema. The panel defined lipedema as a chronic disease characterized by disproportionate, symmetrical expansion of subcutaneous adipose tissue in the extremities, accompanied by pain and sensitivity, with diagnosis relying on clinical history, physical examination, and exclusion of differential diagnoses, as no imaging or laboratory tests are officially approved for diagnostic verification. Conservative management (compression therapy, exercise, nutritional optimization, and Complex Decongestive Therapy) aims at symptom alleviation but does not achieve long-lasting benefits and cannot prevent disease progression. The panel reached consensus that lipedema reduction surgery is the only technique for removing pathological tissue and slowing progression, should be performed by providers with extensive lipedema knowledge as part of an integrated approach, and that lymph vessel-sparing surgery should be considered when there is potential for positive symptom impact. When lipedema coincides with obesity, treatment for obesity should be prioritized before surgery. The panel noted limited evidence overall, highlighting the need for further research and standardized reporting.

Vazirnia et al (2026) conducted a systematic review of 61 studies, composed of observational cohorts and case series with few randomized trials, evaluating lipedema diagnosis, clinical manifestations, and therapeutics, grading evidence using a modified Oxford scale. Conservative therapies including ketogenic diets, compression therapy, and aquatic exercise were associated with reduced pain and swelling (Grade 2A–2B evidence). Tumescent liposuction received a Grade 1 recommendation based on the strongest available evidence for sustained improvement in symptoms, mobility, and quality of life. The authors noted that lipedema is a distinct, progressive condition requiring early recognition and intervention. Conservative therapies may provide partial relief, but tumescent liposuction remains the most effective treatment. Standardized diagnostic criteria, validated patient-reported outcomes,

and clearer guidelines are needed to harmonize care and improve long-term outcomes.

## PROFESSIONAL GUIDELINE(S)

Abdominoplasty

In 2018, the American Society of Plastic Surgeons (ASPS) reaffirmed the recommended insurance coverage criteria for third-party payers related to abdominoplasty. When abdominoplasty is performed solely to enhance 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.

Panniculectomy

In 2017, the ASPS issued a practice parameter for the surgical treatment of skin redundancy for obese and massive weight loss patients, outlining preoperative assessment and screening, management (e.g., timing, operative treatment), and postoperative care. A 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. Body contouring surgery is ideally performed after the patient maintains a stable weight for two (2) to six (6) months. For post-bariatric surgery patients, this often occurs 12 to 18 months after surgery or at the 25 $kg/mg^2$ to 30 $kg/mg^2$ weight range (ASPS 2017).

In 2019, the ASPS re-approved the recommended insurance coverage criteria for third-party payers related to panniculectomy. 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.

Liposuction for Lipedema

In 2022, the National Institute for Health and Care Excellence issued clinical guidance on liposuction for lipedema, recommending that liposuction for lipedema should be used only in the context of research because the evidence on safety and efficacy is inadequate.

## REGULATORY STATUS

Not Applicable

## CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

## CPT Codes

| Code | Description |
|---|---|
| 15830 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy |
| 15832 | ; thigh |
| 15833 | ; leg |
| 15834 | ; hip |
| 15835 | ; buttocks |
| 15836 | ; arm |
| 15837 | ; forearm or hand |
| 15838 | ; submental fat pad |
| 15839 | ; other area |
| 15847 (NMN) | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)<br>(List separately in addition to code for primary procedure) |
| 15876 | Suction assisted lipectomy; head and neck |
| 15877 (*NMN) | Suction assisted lipectomy; trunk<br>(*NMN when billed for abdominoplasty or belt lipectomy.) |
| 15878 | ; upper extremity |
| 15879 | ; lower extremity |



## HCPCS Codes

| Code | Description |
|---|---|
| Not Applicable | |

## ICD10 Codes

| Code | Description |
|---|---|
| Multiple Codes | |

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## SEARCH TERMS

Not Applicable

## CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Abdominoplasty and panniculectomy are not addressed in National or Regional Medicare coverage determinations or policies.

## PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

## POLICY HISTORY/REVISION

### Committee Approval Dates

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|---|
| 03/28/02, 03/27/03, 04/22/04, 05/27/04, 08/04/04, 08/25/05, 06/22/06, 04/26/07, 04/24/08, 04/23/09, 04/29/10, 04/28/11, 04/26/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 06/22/17, 04/26/18, 04/25/19, 04/23/20, 04/22/21, 04/21/22, 04/20/23, 06/20/24, 05/22/25, 05/21/26 |

| Date | Summary of Changes |
|---|---|
| 05/21/26 | • Annual review, policy intent unchanged. |
| 05/22/25 | • Annual review, title updated to reflect that lipedema reduction surgery criteria was merged from the Cosmetic and Reconstructive Surgery CMP 7.01.11. |
| 01/01/25 | • Summary of changes tracking implemented. |
| 03/28/02 | • Original effective date |