KAISER PERMANENTE

Northwest Region Utilization Review

UR 20.2 Panniculectomy and Removal of Excess/Redundant Skin Medical Necessity Criteria

Department: Surgery	Number: UR 20.2
Section: Plastic Surgery	Effective: 4/03
Applies to: KPNW Region	Last Reviewed: 2/20/24
Review Responsibility: UROC	Last Revised: 2/22, 3/22, 2/23
Subject Matter Experts: Jennifer Murphy, MD; Patricia Sandholm, MD; H. Jonathan Chong, MD (Plastic Surgery)	

MEDICAL NECESSITY CRITERIA AND OTHER REQUIREMENTS FOR PANNICULECTOMY AND REMOVAL OF EXCESS/REDUNDANT SKIN

Medical necessity criteria and policy are applied only after member eligibility and benefit coverage is determined. Questions concerning member eligibility and benefit coverage need to be directed to Membership Services.

DEFINITIONS

Panniculectomy: The excision of an apron of abdominal tissue overhanging the inguinal crease (panniculus).

Abdominoplasty: Cosmetic abdominal contouring surgery that includes skin removal.

See the Evidence of Coverage (EOC) as definitions of *Cosmetic Services* vary within the Exclusions section of the EOC documents.

POLICY AND CRITERIA

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	LCD L37020 "Plastic Surgery"
Local Coverage Article	A57222 Billing and Coding: Plastic Surgery
Kaiser Permanente Medical Policy	For Medicare lines of business, apply the criteria in the LCD for panniculectomy. If request is for removal of excess skin or tissue other than panniculus, use the KP criteria below.

For Non-Medicare Members

CRITERIA FOR ABDOMINAL PANNICULECTOMY CONSULTATION AND/OR SURGERY

Panniculectomy may be considered medically necessary in the following situations:

A. Panniculectomy is being requested by a surgeon because of difficult surgical access, where the panniculus will interfere with surgery,

OR

B. Panniculectomy is being requested by a patient who meets ALL of the following criteria:

1. The panniculus hangs below the level of the mons pubis (hair bearing area) and completely covers the mons pubis on direct (un-angled) frontal view.
2. There is documentation that the panniculus:
   a. interferes with ambulation OR
   b. causes recurrent chronic rashes, infections, cellulitis, or non-healing ulcers under the panniculus with documentation of at least a 3-month trial and failure of treatment with prescribed or over-the counter topical medications.
3. Patient's weight has reached a plateau for at least the last 6 months (within 10 lbs of current weight), AND 1 of the following:
   a. Pt with no history of bariatric surgery.
   b. For patients with history of bariatric surgery, 18 months or more has elapsed following bariatric surgery (total of 18 months from day of surgery, including stable weight during the last 6 months).
4. Members with a history of tobacco products* use must have:
   a. a documented “quit” date >6 months prior to referral for consultation, **or**
   b. a negative urine anabasine test (level below 3 ng/dl) within the last 30 days if quit $\leq$6 months prior to referral for consultation.

*tobacco products: cigarettes, cigars, pipe tobacco, e-cigarettes, smokeless tobacco (chewing tobacco and snuff)

CRITERIA FOR REMOVAL OF EXCESS/REDUNDANT SKIN OR TISSUE CONSULTATION AND/OR SURGERY
(other than abdominal fat/panniculus)

Excess/redundant skin or tissue removal may be considered medically necessary in the following situations:

1. Excess/redundant skin or tissue removal is being requested by a surgeon because of difficult surgical access, where the excess/redundant skin or tissue will interfere with surgery,

OR

2. Excess/redundant skin or tissue removal is being requested by a patient with documented recurrent chronic rashes, infections, cellulitis, or non-healing ulcers under the excess skin or tissue with documentation of at least a 3-month trial and failure of treatment with prescribed or over-the counter topical medications.

AND

3. Members with a history of tobacco products* use must have:

a. a documented "quit" date >6 months prior to referral for consultation, **or**

b. a negative urine anabasine test (level below 3 ng/dl) within the last 30 days if quit ≤6 months prior to referral for consultation.

*tobacco products: cigarettes, cigars, pipe tobacco, e-cigarettes, smokeless tobacco (chewing tobacco and snuff).

CONTRAINDICATIONS (TO BE DETERMINED BY THE SURGEON)

1. Nicotine use, including tobacco products* and nicotine replacement therapy (NRT) products** within the 30 days prior to surgery.

*tobacco products: cigarettes, cigars, pipe tobacco, e-cigarettes, smokeless tobacco (chewing tobacco and snuff)

**NRT products: nicotine gum, lozenges, sublingual tablets, transdermal patch, nasal spray, inhaler.

2. Uncontrolled diabetes as indicated by a HbA1c of 8.0 or higher.
3. Any other surgical contraindications will be determined by the surgeon.

OTHER REQUIREMENTS

Relevant history and physical findings establishing medical necessity must be documented.

Panniculectomy or abdominoplasty, with or without diastasis recti repair, for the treatment of back pain or knee pain is not considered medically necessary.

Cosmetic services (see definition above) are specifically excluded by the members' benefit coverage. This exclusion does not apply to services that are covered under "Reconstructive Surgical Services" or services that are medically necessary.

SPECIAL GROUP CONSIDERATIONS for the criteria, which applies if a group has the benefit coverage:

Criteria apply to Commercial members
Oregon Medicaid: subject to eligibility on OHP Linefinder
WA Medicaid/Molina: these criteria do not apply, refer to WA State Health Care Authority Provider Billing Guide

RATIONALE

EVIDENCE BASIS

Panniculectomy:

A 2018 systematic review of the effects of body contouring surgery (including panniculectomy) on post-bariatric patients reports significant improvement in physical functioning, psychological well-being, and global quality of life scores following body contouring surgery.[1]

Tobacco Use:

A 2018 systematic review of the effect of smoking on post-operative outcomes in patients who had common elective procedures in plastic surgery reports that tobacco use was associated with a significant increase in the total number of post-operative complications following abdominoplasty.[2] These complications include wound healing due to increased incidence of flap necrosis, infection, and wound separation in, all of which were significantly more common among smokers compared to non-smokers.[2] A 2015 systematic review of the association between smoking status and outcomes of plastic surgery reports significantly increased odds of surgical site infections, delayed wound healing, and cutaneous necrosis among patients who were smokers compared to non-smokers.[3]

REFERENCES

1. Toma T, Harling L, Athanasiou T, Darzi A, Ashrafian H. Does Body Contouring After Bariatric Weight Loss Enhance Quality of Life? A Systematic Review of QOL Studies. *Obes Surg*. Oct 2018;28(10):3333-3341. doi:10.1007/s11695-018-3323-8

2. Theocharidis V, Katsaros I, Sgouromallis E, et al. Current evidence on the role of smoking in plastic surgery elective procedures: A systematic review and meta-analysis. *J Plast Reconstr Aesthet Surg*. May 2018;71(5):624-636. doi:10.1016/j.bjps.2018.01.011

3. Pluvy I, Panouillères M, Garrido I, et al. Smoking and plastic surgery, part II. Clinical implications: a systematic review with meta-analysis. *Ann Chir Plast Esthet*. Feb 2015;60(1):e15-49. doi:10.1016/j.anplas.2014.09.011

4. Xu, Z., Norwich-Cavanaugh, A., Hsia, HC (2019), Can Nicotine Replacement Decrease Complications in Plastic Surgery? *Annals of Plastic Surgery*. 83: S55-S58.

5. Apfelberg, DB., Results of Multicenter Study of Laser-assisted Liposuction (Clin Plast Surg.), 23(4) (1996), 713-719

6. Elbaz, JS., Flageul, G. and Olivier-Masveyraud, F. Classical Abdominoplasty (Ann Chir Plast Esthet.), 44(4) (1999) 443-461

7. Guiding Principles for Liposuction The American Society for Dermatologic Surgery (Dermatol Surg.), 23(12) (February 1997),1127-1129

8. Lockwood, T., Rectus Muscle Diastasis in Males: Primary Indication for Endoscopically Assisted Abdominoplasty. (Plast Reconstr Surg.), 101(6) (1998), 1685-1691

9. Manassa, E., Hertl, C., Olbrisch, R., "Wound Healing Problems in Smokers and Nonsmokers after 132 Abdominoplasties" (American Society of Plastic Surgeons), (Plastic and Reconstructive Surgery), (May 2003), 2082-2087

10. Matarasso, A., and Matarasso, SL., "When Does Your Liposuction Patient Require an Abdominoplasty? (Dermatol Surg.), 23(12) (1997) 1151-1160

11. Ramirez, OM., Abdominoplasty and Abdominal Wall Rehabilitation: A Comprehensive Approach. (Plast Reconstr Surg.), 105(1) (2000) 425-435)

12. "Update from the Ultrasonic Liposuction Task Force of the American Society for Dermatologic Surgery (Dermatol Surg.), 23(3) (1997), 211-214