



Geisinger Health Plan Policies and Procedure Manual

Policy: MP056

Section: Medical Benefit Policy

Subject: Management of Excessive Skin and Subcutaneous Tissue

Applicable line of business:

Commercial	x	Medicaid	x
Medicare	x	ACA	x
CHIP	x		

I. Policy: Management of Excessive Skin and Subcutaneous Tissue

II. Purpose/Objective:

To provide a policy of coverage regarding Management of Excessive Skin and Subcutaneous Tissue

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

Commercial

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:

Panniculectomy, Lipectomy, Liposuction, Abdominoplasty:

Defined as excision of excessive skin and subcutaneous tissue including but not limited to Panniculectomy (Abdominoplasty) or Lipectomy by any other method (excision, suction assisted, liposuction, aspiration) and may involve areas such as but not limited to head and neck, upper and lower extremities, abdomen, breasts, back, pelvis, buttocks, hips and other areas not specifically listed.

INDICATIONS: REQUIRES PRIOR MEDICAL DIRECTOR or DESIGNEE AUTHORIZATION (For lines of business in which coverage is not explicitly excluded).

A member enrolled in a contract in which coverage is not explicitly excluded, may be eligible for an abdominoplasty or panniculectomy when **ALL** the following are met:

1. The pannus hangs below the level of the pubis; **AND**
2. One of the following:
 - a. medical documentation of recurrent or chronic rashes, infections, chronic or recurrent intertrigo, candidiasis, cellulitis or tissue necrosis with inpatient or outpatient follow-up required; **OR**
 - b. medical documentation of difficulty with ambulation and interference with the activities of daily living; **AND**
3. Symptoms or functional impairment persists despite significant weight loss defined as at least a 100 lb. weight loss or a weight loss which is 40% or greater of the excess body weight that was present prior to the member's weight loss program or surgical intervention, which has been stable for at least 3 months; **AND**
4. If the member has had bariatric surgery, they are at least 12 months post-operative and have documented stable weight for at least 3 months.

A member, enrolled in a contract in which coverage is not explicitly excluded, may be eligible for surgical management of excessive skin and subcutaneous tissue when **ALL** the following are met:

One of the following:

- a. medical documentation of recurrent or chronic rashes, infections, chronic or recurrent intertrigo, candidiasis, cellulitis or tissue necrosis with inpatient or outpatient follow-up required; **OR**
- b. medical documentation of difficulty with ambulation and/or interference with the activities of daily living; **AND**

If the member has had bariatric surgery, they are at least 12 months post-operative and have documented stable weight for at least 3 months

EXCLUSIONS:

Members may **NOT** be eligible for surgical management of excessive skin and subcutaneous tissue for any indications other than those listed above, including but not limited to:

- Restorative or reconstructive surgery performed for cosmetic purposes and from which no significantly improved physiologic function as determined by the Plan is anticipated, is **NOT COVERED**.
- Repair of a diastasis, defined as a thinning of the anterior abdominal wall fascia, in the absence of a true midline (ventral) hernia, is not considered medically necessary because it is not associated with conditions of clinical significance.
- Solely to treat back pain, or when performed in conjunction with abdominal or gynecological procedures (e.g. abdominal hernia repair, hysterectomy), unless the above criteria for panniculectomy or abdominoplasty are met separately.

The Plan does not provide coverage for abdominal suction-assisted lipectomy or liposuction because it is considered cosmetic and **NOT COVERED**.

The Plan does not provide coverage for labiaplasty for indications other than gender reassignment or surgical reconstruction following trauma or surgical treatment of disease (e.g., oncological surgery). Other indication for labiaplasty are considered cosmetic and **NOT COVERED**.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Management of Excessive Skin and Subcutaneous Tissue

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

CPT/HCPCS Codes:

- 00802** Anesthesia for procedures on lower anterior abdominal wall; panniculectomy
- 15830** Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
- 15832** Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh
- 15833** Excision, excessive skin and subcutaneous tissue (including lipectomy); leg
- 15834** Excision, excessive skin and subcutaneous tissue (including lipectomy); hip
- 15835** Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock
- 15836** Excision, excessive skin and subcutaneous tissue (including lipectomy); arm
- 15837** Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand
- 15838** Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad
- 15839** Excision, excessive skin and subcutaneous tissue (including lipectomy); other area
- 15847** Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial placcation)
- 15876** Suction assisted lipectomy; head and neck
- 15877** Suction assisted lipectomy; trunk
- 15878** Suction assisted lipectomy; upper extremity
- 15879** Suction assisted lipectomy; lower extremity

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 4/98

Revised: 12/01, 2/03, 2/04 (diastasis exclusion); 2/05, 2/06 (Definitions, coding); 2/07; 10/09 (criteria), 11/15 (Added Indications); 11/16, 11/18 (clarify indications and exclusions); 10/20 (add labiaplasty exclusion)

Reviewed: 3/08; 11/10, 11/11, 11/12, 11/13, 11/14, 10/17, 10/19, 10/21, 10/22, 10/23, 10/24

CMS UM Oversight Committee Approval: 12/23, 12/24

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.