

# MEDICA<sup>®</sup>

## UTILIZATION MANAGEMENT POLICY

TITLE: ABDOMINOPLASTY/PANNICULECTOMY

Origination Date: May, 1996

Subsequent Endorsement Date(s): 06/1997, 06/1998, 05/1999, 05/2000, 05/2001, 05/2002, 05/2003, 06/2004, 06/2005, 02/2006, 06/2006, 06/2007, 06/2008, 06/2009, 06/2010

*This policy was developed with input from specialists in plastic surgery and general surgery, and endorsed by the Medical Policy Committee.*

### PRODUCT APPLICATION

*This policy provides general information concerning Medica's administrative processes. It applies to all fully insured Medica Health Plans, Medica Insurance Company, and Medica Health Plans of Wisconsin products, unless a specific limitation or exception exists. For self-insured plans, consult individual plan sponsor benefit documents. If there is a discrepancy between a Utilization Management Policy and a self-insured benefit plan, the provisions of the benefit plan will govern. With respect to Medicare and Medicaid members, this policy will apply unless Medicare or Medicaid policies require different coverage.*

### IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

*Medica updates its Utilization Management Policies regularly, and reserves the right to amend these policies without notice to Medica members. Medica also reserves the right to amend these policies without notice to contracted health care providers unless the amendment materially alters the policy. If the amendment materially alters the policy, Medica will disclose the change to contracted health care providers not less than 45 days prior to implementation of the policy. Medica's Utilization Management Policies contain general information only and do not guarantee coverage. Receipt of benefits is subject to all terms and conditions of the member's coverage document. Members should consult their Certificates of Coverage or Plan Documents/Summary Plan Descriptions to review the provisions relating to a specific coverage determination. If there is a conflict between a Utilization Management Policy and the applicable coverage document, the coverage document will govern. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Utilization Management Policy may call Medica's Provider Service Center toll free at 1-800-458-5512.*

*Medica's Utilization Management Policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.*

### PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of abdominoplasty/panniculectomy. The Coverage Issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

### BACKGROUND

#### I. Definitions

- A. A **ventral hernia** normally occurs in the abdominal wall at the site of a previous surgical incision. It may also occur at the umbilicus or other area of the abdominal wall. Weakened fascia or muscles results in a bulge or tear in the abdominal wall, allowing the inner lining of the abdomen and/or intestinal loop to extend through the abdominal wall.
- B. **Diastasis recti (rectus diastasis)** is the separation of the two rectus muscles along the median line of the abdominal wall, resulting in abdominal wall laxity. Diastasis recti is not considered a true hernia.
- C. **Abdominoplasty** is a surgical procedure to tighten a lax anterior abdominal wall and remove excess abdominal skin. Abdominoplasty involves resection of skin and fat, and may involve tightening of the abdominal wall through placement of sutures.

- D. **Panniculectomy** is the surgical resection of a panniculus and involves resection of skin and fat (lipectomy), without muscle tissue resection. It can be performed alone or in conjunction with another abdominal surgery or with abdominoplasty.
- E. A **panniculus** is excess adipose tissue hanging downward from the abdomen and resembles an "apron of skin" overlying the front of the pelvic girdle.
- F. The **symphysis pubis** is the area of junction of the pubic bones and lies at the center-front of the pelvic girdle.
- G. **Intertriginous rash** results from dermatitis occurring between juxtaposed folds of skin. The dermatitis is usually caused by retention of sweat, moisture, and warmth which results in an overgrowth of normal skin microorganisms.
- H. **Cellulitis** is an acute spreading bacterial infection (usually *Staphylococcus aureus* or Group A *Streptococcus*) in the deeper layers of the skin (i.e., the dermis and subcutaneous tissues). It is characterized by erythema, warmth, swelling, pain, fever, and malaise. Cellulitis commonly appears in areas where there is a break in the skin from an abrasion, a cut, or skin ulceration. Standard treatment is antibiotic therapy.
- I. **Necrosis** is the death of living cells and tissue. Necrosis is caused by localized tissue injury, such as corrosion or erosion, a lesion or ulceration, or loss of blood supply.
- J. **Skin ulceration** is a break in the skin with accompanying loss of surface tissue with disintegration and necrosis of underlying tissue.

II. Comments

- A. The presence of a diastasis recti does not automatically equate to the presence of a ventral hernia.
- B. A panniculus may exist with or without the presence of a ventral hernia or diastasis recti.

MEDICAL NECESSITY CRITERIA

I. Indications

- A. A panniculus that extends to or beyond the level of the symphysis pubis,

**AND**

- B. One of the following situations exists:
    - 1. Unrelated or separate abdominal surgery requiring improved surgical access and post-operative wound healing, (for example; repair of a large ventral hernia associated with a large pannus),
- <OR>**
- 2. A chronic intertriginous rash causing cellulitis, skin necrosis, or ulceration unresponsive to medical treatment.

II. Written documentation from the medical record specifying the medical necessity according to the above criteria may be required. Requested documentation may include, but is not limited to:

- A. A panniculus that extends to or below the level of the symphysis pubis. Front and lateral photographs demonstrating the size of the pannus must be submitted.
- B. Abdominal surgical procedure being performed, as applicable.
- C. Severity and type of skin condition(s) associated with the panniculus, as applicable.
- D. When associated with significant weight loss, maintenance of a stable weight for a minimum of six months.

III. Diastasis recti is generally not clinically significant and does not require treatment. Therefore, abdominoplasty for the sole purpose of repairing diastasis recti is not considered medically necessary, except when loss of abdominal musculature may impair the patient's ability to lift or carry (during) normal daily activities.

COVERAGE ISSUES

- 1. Prior authorization **is required** for abdominoplasty/panniculectomy.
- 2. Coverage may vary according to the terms of the member's coverage document.
- 3. Repeat or revision requests require Medical Director review.
- 4. For Medicare members, refer to the following, as applicable:

- For Minnesota: Wisconsin Physicians Service Insurance Corporation. *Local Coverage Determination (LCD) for Cosmetic and Reconstructive Surgery (L17993)*. Available at: [http://www.cms.gov/mcd/viewlcd.asp?lcd\\_id=17996&lcd\\_version=18&basket=lcd%3A17996%3A18%3ACosmetic+and+Reconstructive+Surgery%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800954%29%3A](http://www.cms.gov/mcd/viewlcd.asp?lcd_id=17996&lcd_version=18&basket=lcd%3A17996%3A18%3ACosmetic+and+Reconstructive+Surgery%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800954%29%3A). Accessed April 19, 2010.
  - For Wisconsin: Wisconsin Physicians Service Insurance Corporation. *Local Coverage Determination (LCD) for Cosmetic and Reconstructive Surgery (L17993)*. Available at: [http://www.cms.gov/mcd/viewlcd.asp?lcd\\_id=17993&lcd\\_version=20&basket=lcd%3A17993%3A20%3ACosmetic+and+Reconstructive+Surgery%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800951%29%3A](http://www.cms.gov/mcd/viewlcd.asp?lcd_id=17993&lcd_version=20&basket=lcd%3A17993%3A20%3ACosmetic+and+Reconstructive+Surgery%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800951%29%3A). Accessed April 19, 2010.
  - For North Dakota and South Dakota: Noridian Administrative Services, LLC. *Local Coverage Determination (LCD) for Plastic Surgery (L24349)*. Refer to the Medicare Coverage Database Search Page, available at: [http://www.cms.hhs.gov/mcd/search.asp?](http://www.cms.hhs.gov/mcd/search.asp) Accessed April 19, 2010.
  - For other states, refer to the Medicare Coverage Database Search Page, available at: [http://www.cms.hhs.gov/mcd/search.asp?](http://www.cms.hhs.gov/mcd/search.asp)
5. This policy outlines the reconstructive criteria for abdominoplasty/panniculectomy in accordance with the reconstructive definition within the member's coverage document.
  6. Cosmetic surgery is generally an exclusion in the member's coverage document.
  7. The following procedures are considered cosmetic and excluded from coverage:
    - a. Panniculectomy and abdominoplasty not meeting the above Medical Necessity Criteria
    - b. Mini-abdominoplasty
    - c. Suction assisted lipectomy (liposuction) as a primary procedure
  8. If two or more procedures (one cosmetic and one reconstructive) are performed during the same operative session, the surgeon must delineate the cosmetic and reconstructive components associated with the procedure.
  9. If the Medical Necessity and Coverage Criteria are met, Medica staff will authorize benefits within the limits in the member's coverage document.
  10. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica Provider Administrative Manual.

#### References:

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