Policy:
The following guidelines address MHP coverage for procedures performed to either remove tighten or repair excess skin and or subcutaneous tissue in the truncal region. According to the American Society of Plastic and Reconstructive Surgeons, the specialty of plastic surgery includes reconstructive and cosmetic procedures:

1. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involutional defects, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.
2. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Procedure:
Specific Diagnoses:
1. Panniculectomy/Abdominoplasty
   a. The procedure must be prior-authorized by Meridian Health Plan (MHP).
   b. MHP considers Panniculectomy medically necessary according to the following criteria:
      i. Pannicus hangs below the level of the pubis; and
      ii. The member’s treating physician must document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over 6 months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of 6 months.
      iii. Excision of excessive skin and subcutaneous tissue (including Lipectomy) of the abdomen (Abdominoplasty) (15830) will only be considered reasonable and medically necessary when
these procedures are performed in conjunction with an abdominal surgery being done at the same
time and allowing the tissue to remain would affect the healing of the surgical incision.
iv. This procedure may also be considered to be medically necessary for the patient that has had a
significant weight-loss following the treatment of morbid obesity and there are medical
complications such as candidiasis, intertrigo or tissue necrosis that is unresponsive to oral or
topical medication or physical aids.
v. If the procedure is being performed for intertrigo, consultation with a dermatologist must be
present.
c. MHP considers Abdominoplasty (Excision of excessive skin and subcutaneous tissue (including
Lipectomy) of the abdomen) medically necessary according to the following criteria:
i. When these procedures are performed in conjunction with an abdominal surgery being done at
the same time and allowing the tissue to remain would affect the healing of the surgical
incision.
ii. This procedure may also be considered to be medically necessary for the patient that has had a
significant weight-loss following the treatment of morbid obesity and there are medical
complications such as candidiasis, intertrigo or tissue necrosis that is unresponsive to oral or
topical medication or physical aids that consistently recurs over 6 months while receiving
appropriate medical therapy, or remains refractory to appropriate medical therapy over a period
of 6 months.
   a. If the procedure is being performed for intertrigo, consultation with a
dermatologist must be present.
d. MHP considers Panniculectomy cosmetic when these criteria are not met.
i. If the procedure is being performed following significant weight loss, in addition to meeting the
criteria noted above, there should be evidence that the individual has maintained a stable weight
for at least six months. If the weight loss is the result of bariatric surgery,
Abdominoplasty/Panniculectomy should not be performed until at least 18 months after bariatric
surgery and only when weight has been stable for at least the most recent six months.
ii. Pictures of documentation demonstrating the pannus below the pubis and tissue involvement are
required prior to authorization.

2. Suction Lipectomy/Lipoabdominoplasty
   a. MHP considers suction Lipectomy or Lipoabdominoplasty to be cosmetic because they are not associated
with functional improvements.

Line of Business Applicability:
This policy applies to Michigan Medicaid, Illinois Medicaid, and Individual Plans.

For Medicaid/Medicaid Expansion Plan members, this policy will apply. Coverage is based on medical necessity
criteria being met and the codes being submitted and considered for review being included on either the Michigan
Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-
159815--.00.html), or the Illinois Medicaid Fee Schedule (located at:
http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If there is a discrepancy
between this policy and either the Michigan Medicaid Provider Manual (located at:
http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--.00.html), or the Illinois Medicaid Provider Manual
(located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid
Provider Manual will govern.

For Individual members, consult the individual insurance policy. If there is a discrepancy between this policy and the
individual insurance policy document, the guidelines in the individual insurance policy will govern.

State specific special instructions:
None: ☒
References:

5. Guidelines from the Board of Governors of the Society of American Gastrointestinal and Endoscopic Surgeons. August 2014

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