KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Restorative and Cosmetic Procedures

- Abdominoplasty
- Lipectomy
- Panniculectomy

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	Medicare Benefit Policy Manual Chapter 16 - General Exclusions from Coverage, Section 120
National Coverage Determinations (NCD)	Plastic Surgery to Correct "Moon Face" 140.4
Local Coverage Determinations (LCD)	Plastic Surgery (L37020)
Local Coverage Article	Billing and Coding: Plastic Surgery (A57222)

For Non-Medicare Members

Cosmetic Surgery is performed to reshape normal structures of the body in order to improve appearance in the absence of a specific functional improvement. Surgery performed to improve on "natural" appearance or performed purely for the purpose of enhancing one's normal appearance is not considered reasonable and necessary.

Reconstructive Surgery is performed to restore bodily function or to correct a deformity resulting from disease, injury, trauma, birth defects, congenital anomalies, infections, burns, or previous medical treatment, such as surgery or radiation therapy. The primary goal is to restore function. Reconstructive surgery is reasonable and necessary to improve the functioning of a malformed body part. Please refer to member's contract for specific coverage regarding congenital anomalies.

For the procedures in this policy plastic surgery credentials are preferred and may be medically necessary when the following criteria are met:

I. **Abdominoplasty**
1. Abdominoplasties are not covered as they are considered cosmetic.
2. Diastasis recti treatment - Treatment of diastasis recti is considered cosmetic as the separation/laxity of the muscles of the abdominal wall is not considered a true hernia and the treatment does not address a physical functional condition.

II. **Panniculectomy**: is covered when **ALL of the following** criteria are met:
1. Panniculus hangs below the level of the pubis (documented by photographs)
2. Documentation in the medical record of the presence of significant complications including one or more of the following, requiring at least two office visits for treatment:
    a. The excess skin is the primary cause of at least one episode of cellulitis requiring systemic (oral or intravenous) antibiotics

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b. Transdermal skin ulcerations in the skin folds that are recurrent or refractory to medical treatment.

3. 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, procedure should not be performed until at least 18 months after bariatric surgery.
4. There is a functional deficit (interference with activities of daily living) due to a severe physical deformity or disfigurement resulting from the excess skin.
5. The surgery is expected to restore or improve the functional deficit.
6. BMI must be < 35
7. No diabetes, or diabetes with HbA1c < 7.5
8. Members who use nicotine/tobacco must be actively involved in a nicotine cessation program and must be nicotine/tobacco-free for a minimum of 30 days prior to surgery
9. Not covered when performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy are met separately
10. Not covered to minimize the risk of hernia formation or recurrence

III. Liposuction for Lipedema

1. Liposuction or lipectomy to treat lipedema of the extremities may be considered medically necessary when all of the following are met (A.-G.):
   a. Surgical interventions are performed by hospital credentialed, board certified plastic surgeon; and
   b. The individual has a diagnosis of lipedema including all of the following clinical exam findings:
      i. Bilateral symmetric adiposity that is disproportionately affecting the extremities with minimal involvement of the hands and feet; and .
      ii. Non-pitting edema; and
      iii. Pain and tenderness on palpation of the affected areas; and
      iv. Negative Stemmer sign; and
      v. Submission of photographs documenting the affected extremities requested for treatment and are consistent with the diagnosis of lipedema; and
   c. There is documentation of significant physical **functional impairment** (e.g., difficulty ambulating or performing activities of daily living); and
   d. The individual has not responded to at least three consecutive months of optimal medical management including complex decongestive therapy and compression therapy; and
   e. For individuals with BMI greater than 35 kg/m2, there has been a lack of effect on lipedema-affected areas of weight loss measures as documented in the medical records through nutrition and/or medical interventions with clinic visits over three consecutive months; and
   f. The plan of care postoperatively is to wear compression garments as instructed to maintain the benefits of treatment; and
   g. The area requested to be treated has not previously been treated with liposuction or lipectomy.
2. Liposuction or lipectomy to treat lipedema for areas other than extremities (e.g., trunk or back) or when Criterion I. is not met is considered investigational.
3. Lymphatic physiologic surgery with or without a microscope to treat lymphedema (including, but not limited to, lymphatico-lymphatic bypass, lymphatic-venous-lymphaticplasty, lymphovenous bypass, lymphaticovenous anastomosis, autologous lymph node transplantation, lysis of vein adhesions, and vascularized lymph node, omental, or other tissue transfer) is considered investigational.
4. Lymphatic physiologic surgery with or without a microscope performed during nodal dissection (e.g. axillary or groin) or breast reconstruction to prevent lymphedema (including, but not limited to, the Lymphatic Microsurgical Preventing Healing Approach) in individuals who are being treated for breast cancer is considered investigational.
5. Liposuction or lipectomy to treat lymphedema (including, but not limited to, lipectomy, suction-assisted protein lipectomy, liposuction, and lymph-sparing liposuction) is considered investigational.

IV. Procedures to remove excess skin in the arms, buttocks, hips, legs, thighs, or torso are considered cosmetic as these procedures do not address any physical functional condition.

V. Dental/orthodontic procedures for craniofacial anomalies – for baseline policy for all plans, click here to view the policy.

See individual links below for the following potentially cosmetic procedures:

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- Blepharoplasty
- Dermatology Services
- Dermal Fillers for Facial Lipoatrophy (Sculptra/Radiesse)
- Reduction Mammoplasty
- Rhinoplasty
- Breast Reconstruction
- Skin Lesions
- Vein Procedures

The following are considered cosmetic in nature and non-covered under member's contract:

- Cervicoplasty ("neck lift")
- Collagen injection
- Hair Transplant
- Canthoplasty ("outer eyelid lift surgery") except in the setting of skin cancer excision

If requesting this service, please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Kaiser Permanente coverage contracts exclude cosmetic procedures. However, some procedures may be medically necessary when certain clinical criteria have been met. This document has been created to provide guidance to physician's reviewers when reviewer requests to cover potentially cosmetic services.

Evidence and Source Documents

Member contract

References

Liposuction for Lipedema

April 27, 2020: INTC Review

Evidence Conclusion: There is insufficient evidence regarding the efficacy and safety of liposuction compared to conventional treatments (compression therapy, exercise, or massage) for lipedema. The existing evidence is of insufficient quantity and quality.

The existing body of evidence on the surgical management of lipedema is sparse and limited to six low-quality observational studies, a majority of which were conducted in Germany, among 575 patients and included in two technology assessments. The low-quality evidence reported positive improvements in pain, mobility, bruising, sensitivity to pressure, appearance and quality of life with no report of major complications following liposuction. The diagnostic criteria for the condition is contested and remains unclear.

Articles: Liposuction for Lipedema: Technology Assessment (kp.org)

Liposuction for the Treatment of Lipedema

April 19, 2022: Hayes Technology Assessment

Clinical studies: A review of full-text clinical studies suggests minimal support for using liposuction for lipedema. systematic reviews: A review of full-text systematic reviews suggests no/unclear support for using liposuction for lipedema.

Insights

Evidence from 3 very poor-quality studies suggests that liposuction leads to clinically significant improvements in quality of life, disability, and pain and reduced need for conservative treatment in women with lipedema at 2 to 3 years of follow-up. Patients enrolled sought treatment at specialized healthcare centers, increasing risk of selection bias in cases reported. No other treatments for lipedema were identified in the literature beyond traditional conservative care with congestive therapy. Nonserious complications were common (e.g., bruising and postoperative bleeding). All 3 studies in this report are retrospective in design and do not compare liposuction treatment to any other intervention. One clinical study comparing the efficacy and safety of liposuction with

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conservative care is in progress. Clinical practice guidelines and payer policies appear generally supportive of the use of liposuction to treat lipedema.

Hayes. Hayes Technology Assessment. Liposuction for the Treatment of Lipedema. Dallas, TX: Hayes; April 19, 2022. Retrieved September 5, 2024, from https://evidence.hayesinc.com/report/eer.liposuction4059

Applicable Codes

Panniculectomy - Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy

Excision of Excess Skin
Considered Not Medically Necessary

CPT® Codes	Description
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

Abdominoplasty

Medicare - Considered Medically Necessary when criteria in the applicable policy statements listed above are met
Non-Medicare - Considered Not Medically Necessary

CPT® Codes	Description
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)

Lipectomy

Medicare - Considered Medically Necessary when criteria in the applicable policy statements listed above are met
Non-Medicare - Considered Not Medically Necessary

CPT® Codes	Description
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

Cervicoplasty - Considered Not Medically Necessary:

CPT® Codes	Description

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15819	Cervicoplasty

Canthoplasty - Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
67950	Canthoplasty (reconstruction of canthus)

Otoplasty - Considered Not Medically Necessary:

CPT® Codes	Description
69300	Otoplasty, protruding ear, with or without size reduction

Hair Transplant

Medicare - Considered Medically Necessary when criteria in the applicable policy statements listed above are met
Non-Medicare - Considered Not Medically Necessary

CPT® Codes	Description
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts

Tissue Expanders - Considered Not Medically Necessary:

CPT® Codes	Description
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant

Wrinkle Removers - Considered Not Medically Necessary:

CPT® Codes	Description
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap

Collagen Injections - Considered Not Medically Necessary:

CPT® Codes	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

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Date Created	Dates Reviewed	Date Last Revised
07/01/2005	07/01/2005[MDCRPC], 05/30/2006[MDCRPC], 11/20/2006[MDCRPC], 12/22/2006[MDCRPC], 10/15/2007[MDCRPC], 06/09/2008[MDCRPC], 04/13/2009[MDCRPC], 02/2/2010[MDCRPC], 12/07/2010[MDCRPC], 10/04/2011[MDCRPC], 08/07/2012[MDCRPC], 07/02/2013[MDCRPC], 03/04/2014[MPC], 01/06/2015 [MPC], 11/03/2015 [MPC], 09/06/2016[MPC], 07/11/2017[MPC], 06/05/2018[MPC], 06/04/2019[MPC], 06/02/2020[MPC], 06/01/2021[MPC] , 06/07/2022[MPC] 06/06/2023[MPC], 09/03/2024[MPC]	02/04/2025

[MDCRPC] Medical Director Clinical Review and Policy Committee

[MPC] Medical Policy Committee

Revision History	Description
11/01/2015	Changed Medicare links
05/03/2016	Added definitions for Cosmetic vs. Reconstructive Surgery. Added a list of non-covered cosmetic services
12/19/2017	Added LCD 37020
05/18/2020	Added clarifying language to canthoplasty “except in the setting of skin cancer excision”
06/01/2021	Removed reference to retired LCD Cosmetic vs. Reconstructive Surgery (A52729) for Medicare as it was replaced with the Plastic Surgery LCD/LCA. Updated applicable codes.
09/07/2021	MPC approved to adopt updates to the clinical indications for panniculectomy and updated excess skin removal from the arms, buttocks, hips, legs, thighs, or torso to cosmetic/not medically necessary for Non-Medicare members. Requires 60-day notice, effective date February 1, 2022.
11/06/2021	Added clarifying language to Reconstructive Surgery definition “Please refer to member’s contract for specific coverage regarding congenital anomalies.”
11/07/2023	Make the current policy more explicit and provide a summary of medical evidence justifying a position of non-coverage (no 60-day notice). No Vote Required.
12/21/2023	Added NCD Plastic Surgery to Correct "Moon Face" 140.4
12/03/2024	MPC approved to adopt coverage criteria for Liposuction for Lipedema. 60-day notice required. Effective May 1, 2025.

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