



Clinical Review Criteria

Panniculectomy and Removal of Excess/Redundant Skin

- Abdominoplasty

NOTICE: Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited.

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Clinical Review Criteria, at Kaiser Permanente's sole discretion, at any time, with or without notice. **Member contracts differ in health plan benefits. Always consult the patient's Evidence of Coverage or call Kaiser Permanente Member Services at 1-888-901-4636 (TTY 711), Monday through Friday, 8 a.m. to 5 p.m. to determine coverage for a specific medical service.**

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 (L35163)
Local Coverage Article	Billing and Coding: Plastic Surgery (A57221)

For Non-Medicare Members

Effective until July 1, 2026

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

OR

- 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

Effective July 1, 2026

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.

Panniculectomy is a surgical procedure used to remove a panniculus, which is an apron of fat and skin that hangs from the front of the abdomen. In certain circumstances, the panniculus can be associated with skin irritation and infection due to interference with proper hygiene and constant skin-on-skin contact in the fold's daily activities.

Abdominoplasty is typically performed for cosmetic purposes, involves the removal of excess skin and fat from the pubis to the umbilicus or above, and may include tightening of the rectus muscle and creation or transposition of the umbilicus

Panniculectomy is considered medically necessary when ALL the following conditions are met:

- Pannus is a grade II or higher as documented by clinical notes and/or pre-operative notes
- Pannus is documented to have caused recurrent chronic rashes, infections, cellulitis, or non-healing ulcers under the panniculus with documentation of a minimum of a 3-month trial and failure of treatment with prescribed systemic oral or IV antibiotics
- Pannus is documented to cause significant functional impairment to activities of daily living with panniculectomy expected to restore or improve function
- Documentation of a stable weight for at least 6 months, in cases where a bariatric surgery was performed the patient must be 18 months post op with 12 months of documented stabilization of weight AND a BMI <35

Panniculectomy is considered medically necessary when performed in conjunction with abdominal or gynecological procedures where it is documented that the panniculectomy will reduce excessive skin tension that may impair wound healing

Abdominoplasty is considered cosmetic and not medically necessary for all applications. Surgical procedures to correct diastasis recti are considered cosmetic in nature and not medically necessary. Abdominoplasty may be approved, if required for a hernia repair

Other redundant skin and fat removal surgeries, including but not limited to brachioplasty, thigh lift, back lift are generally not covered but may be considered medically necessary when ALL the following conditions are met:

- Documentation of interference with activities of daily living
- Skin breakdown and skin infections including fungal infections due to friction in the intertriginous zones that don't respond to 3 or more months of medical treatment. Medical treatment should consist of good hygiene practices, topical antifungals, topical and/or systemic corticosteroids, and local and/or systemic antibiotics

Excess/redundant skin or tissue removal may be considered medically necessary when it is being requested by a surgeon because of difficult surgical access, where the excess skin or tissue will interfere with surgery or surgical healing

Panniculus Grading Scale:

- Grade 1: The panniculus reaches the pubic hair but not the genitals
- Grade 2: The panniculus lies over the genitals down to the thigh crease
- Grade 3: The panniculus reaches down to the upper thigh
- Grade 4: The panniculus hangs down to the mid-thigh level
- Grade 5: The panniculus reaches the knees

Exclusions

Panniculectomy and excess/redundant skin removal is not considered medically necessary and is not a covered benefit for any of the following indications (list is not inclusive):

- Treatment for neck or back pain
- Minimizing risk for hernia formation or recurrence
- Repairing abdominal wall laxity or diastasis recti
- Suction assisted lipectomy performed alone or not as a part of a medically necessary panniculectomy procedure
- Improved appearance

In addition to the KP National criteria above, KPWA recognizes the following contraindications:

- Current nicotine/tobacco use unless actively enrolled in a tobacco cessation program with a commitment to be nicotine/tobacco-free for a minimum of 30-days prior to surgery.
- Diabetes with poorly controlled blood sugar as evidenced by an HbA1c > 7.5

For covered criteria:

If requesting this service (or these services), 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

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
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
<i>Other nonspecific that may be billed for this procedure include 17999, 22999, 00802</i>	

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)

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

**To verify authorization requirements for a specific code by plan type, please use the [Pre-authorization Code Check](#).

CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Date Created	Date Reviewed	Date Last Revised
02/03/2026	02/03/2026 ^{MPC}	02/03/2026

^{MPC} Medical Policy Committee

Revision History	Description
02/03/2026	MPC approved the proposed KP National Clinical Policy for Panniculectomy/Abdominoplasty & Removal of Redundant Skin. 60-day notice required; effective 07/01/2026.

References:

- Borud LJ, Warren AG. Body contouring in the postbariatric surgery patient. *Journal of the American College of Surgeons* 2006;203(1):82-93.
- Brown M, Adenuga P, Soltanian H. Massive panniculectomy in the super obese and super-super obese: retrospective comparison of primary closure versus partial open wound management. - *Plast. Reconstr. Surg.* - Jan 2014; 133(1); 32-9.
- Evans C, Debord J, Howe H, Marshall JS, Rossi T, Owolabi M. Massive panniculectomy results in improved functional outcome. *American Journal of Surgery* 2014;207(3):441-4.
- Hasanbegovic E, Ahm Sørensen J. Complications following body contouring surgery after massive weight loss: A meta-analysis. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, Mar 2014 67: (3), 295.
- Kuo JH. Panniculectomy in preparation for renal transplantation: a new indication for an old procedure to reduce renal transplantation-associated wound complications. *Plast Reconstr Surg* Dec 2011; 128(6): 1236-40.
- Medicare Coverage Database; No applicable criteria: search terms pannus, panniculectomy, and abdominoplasty. Accessed 2/9/2016.
- O'Brien JA. Fleur-de-lis panniculectomy after bariatric surgery: our experience. *Ann Plast Surg* - Jan 2012; 68(1): 74-8.
- Ortega J. Requirement and postoperative outcomes of abdominal panniculectomy alone or in combination with other procedures in a bariatric surgery unit. *Am J Surg* – Aug 2010; 200(2): 235-40.
- Zannis J, Wood BC, Griffin LP, Knipper E, Marks MW, David LR. Outcome study of the surgical management of panniculitis. *Annals of Plastic Surgery* 2012;68(2):194-7.
- Insurance coverage for massive weight loss panniculectomy: a national survey and implications for policy. Stephanie E. Dreifuss M.D. and J. Peter Rubin M.D. *Surgery for Obesity and Related Diseases*, 2016-02- 01, Volume 12, Issue 2, Pages 412-416, Copyright © 2016 American Society for Bariatric Surgery.