Panniculectomy Surgery (for Idaho Only)

Policy Number: CS093ID.D
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➲ Instructions for Use

Table of Contents **Page**

Application 1
Coverage Rationale 1
Medical Records Documentation Used for Reviews 1
Applicable Codes 1
U.S. Food and Drug Administration 2
References 2
Policy History/Revision Information 2
Instructions for Use 3

Related Policies

- Breast Reconstruction (for Idaho Only)
- Cosmetic and Reconstructive Procedures (for Idaho Only)
- Liposuction for Lipedema (for Idaho Only)
- Omnibus Codes (for Idaho Only)

Application

This Medical Policy only applies the state of Idaho, including Idaho Medicaid Plus plans.

Coverage Rationale

State-Specific Criteria

For medical necessity coverage criteria for panniculectomy, refer to the Idaho Medicaid Provider Handbook, Medical Services, Chapter 5.10: Surgical Procedures for Weight Loss.

Non–State-Specific Criteria

Notes:

- For information on liposuction for lipedema, refer to the Medical Policy titled Liposuction for Lipedema (for Idaho Only).
- For information on liposuction when being performed post-mastectomy, refer to the Medical Policy titled Breast Reconstruction (for Idaho Only).

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Panniculectomy procedures not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed February 13, 2025)

References

Idaho Medicaid Provider Handbook. Medical Services. 5.10. Surgical Procedures for Weight Loss. Available at: https://www.idmedicaid.com/Provider%20Guidelines/Medical%20Services.pdf. Accessed June 5, 2025.

Policy History/Revision Information

Date	Summary of Changes

05/01/2026	**Title Change**
	• Previously titled *Panniculectomy and Body Contouring Procedures (for Idaho Only)*
	Coverage Rationale
	State-Specific Criteria
	• Replaced instruction to "refer to the *Idaho Medicaid Provider Handbook, Medical Services, Chapter 5.10: Surgical Procedures for Weight Loss* for medical necessity clinical coverage criteria for panniculectomy *and abdominoplasty*" with "refer to the *Idaho Medicaid Provider Handbook, Medical Services, Chapter 5.10: Surgical Procedures for Weight Loss* for medical necessity clinical coverage criteria for panniculectomy"
	Non–State-Specific Criteria
	• Removed language indicating body contouring procedures, including but not limited to the following, are considered cosmetic and not medically necessary:
	  ○ Lipectomy, including suction-assisted lipectomy (unless part of an approved procedure)
	  ○ Repair of diastasis recti
	• Updated instruction to refer to the Medical Policy titled *Breast Reconstruction (for Idaho Only) for information on liposuction when being performed* post-mastectomy
	Definitions
	• Removed definition of:
	  ○ Diastasis Recti
	  ○ Functional or Physical or Physiological Impairment
	  ○ Suction Assisted Lipectomy
	Applicable Codes
	• Removed CPT codes 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, and 15876
	Supporting Information
	• Updated *FDA* and *References* sections to reflect the most current information
	• Removed *Description of Services* and *Clinical Evidence* sections
	• Archived previous policy version CS093ID.C

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.