Panniculectomy Surgery

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➲ Instructions for Use

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Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

Coverage Rationale

Panniculectomy

Panniculectomy is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Panniculectomy, Abdominal.

Click here to view the InterQual® criteria.

Panniculectomy is considered cosmetic and not medically necessary when performed for the following indications:

- For any other condition that does not meet the InterQual® criteria
- In conjunction with abdominal or gynecologic surgery, including but not limited to hernia repair, bariatric surgery, C-section, or hysterectomy, unless the member meets the InterQual® CP: Procedures, Panniculectomy, Abdominal criteria
- When performed for primarily cosmetic purposes

Notes:

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

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Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the member specific benefit plan document 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; refer to the guidelines titled Medical Records Documentation Used for Reviews.

Definitions

The following definition may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Panniculectomy: Involves the removal of hanging excess skin/fat in a transverse or vertical wedge but does not include muscle plication, neoumbilicoplasty, or flap elevation. A cosmetic abdominoplasty is sometimes performed at the time of a functional Panniculectomy (American Society of Plastic Surgeons, 2017).

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 the member specific benefit plan document 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

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Description of Services

An abdominal panniculus is an apron of skin and fat that hangs down from the abdomen. This often occurs following massive weight loss and can lead to skin infections, rashes, and difficulty completing activities of daily living (Sachs et al., 2021). A Panniculectomy is a surgery that removes this excess skin and fat but typically does not involve the abdominal muscles (American Society of Plastic Surgeons, 2017).

Benefit Considerations

Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Refer to the member specific benefit plan document.

UnitedHealthcare excludes cosmetic procedures from coverage, including but not limited to the following:

- Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures; the fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness, or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure
- Procedures that do not meet the reconstructive criteria in the Coverage Rationale section

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- Body contouring procedures, including but not limited to:
  - Abdominoplasty
  - Lipectomy, including suction-assisted lipectomy (unless part of an approved procedure); when being performed post-mastectomy, refer to the Medical Policy titled Breast Reconstruction
  - Repair of diastasis recti

Clinical Evidence

Panniculectomy

There is insufficient quality evidence to conclude that panniculectomy performed in conjunction with abdominal or gynecologic surgery, including but not limited to hernia repair, bariatric surgery, C-section, and hysterectomy, outweighs negative outcomes. Additional peer-reviewed literature is needed to determine long-term benefits and the impact on surgical complications and recovery when panniculectomy is performed concurrently.

Dias Rasador et al. (2024) conducted a systematic review and meta-analysis comparing outcomes of ventral hernia repair (VHR) with and without concurrent panniculectomy. Eligible studies included randomized controlled trials and observational studies in adults aged 18 years or older undergoing open VHR, with the intervention defined as simultaneous panniculectomy and the comparator as VHR alone. Thirteen studies (11 observational and two randomized) were included and comprised 23,354 individuals, of whom 2,972 (13%) underwent concurrent panniculectomy. Pooled analyses used random-effects models with risk ratios (RRs) and mean differences and assessed heterogeneity using I^2 statistics. The primary outcome, hernia recurrence measured over 1 to 36 months of follow-up, was significantly lower with concurrent panniculectomy (RR, 0.74; 95% CI, 0.62-0.89; $p < 0.001$; $I^2 = 1\%$), and this reduction persisted in studies with follow-up of longer than 1 year (RR, 0.72; 95% CI, 0.60-0.88; $p < 0.001$; $I^2 = 12\%$). Concurrent panniculectomy increased the risks of surgical site infection (RR, 1.31; 95% CI, 1.13-1.51; $p < 0.001$; $I^2 = 0\%$), surgical site occurrence (RR, 1.49; 95% CI, 1.26-1.77; $p < 0.001$; $I^2 = 11\%$), skin necrosis (RR, 2.94; 95% CI, 1.26-6.85; $p = 0.012$; $I^2 = 0\%$), reoperation (RR, 1.73; 95% CI, 1.32-2.28; $p < 0.001$; $I^2 = 0\%$), and length of stay (mean difference, 0.90 days; 95% CI, 0.40-1.40 days; $p < 0.001$; $I^2 = 56\%$). The prespecified secondary end points included readmission, seroma, hematoma, wound dehiscence, deep venous thrombosis, enterocutaneous fistula, and operative time, which demonstrated no significant differences. The authors concluded that VHR with panniculectomy lowers recurrence rate but increases wound morbidity, reoperation risk, and hospital stay; the authors recommended careful risk-benefit consideration. Limitations include the heterogeneity in panniculectomy indication; lack of reporting on VHR technique, including uncertainty regarding the use of mesh in some studies; absence of rectus diastasis measurement; and omission of certain studies, which may limit comparability and interpretation of pooled results. Additionally, a pooled effect estimate for recurrence may have lost statistical significance. (Elhage et al., 2021, and Diaconu et al., 2019, previously cited in this policy, are included in this systematic review.)

Gebran et al. (2021) performed a retrospective cohort study to evaluate the risk profile of panniculectomy when performed in select patients at the time of bariatric surgery. The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) database (2016-2017), in which data on 379,544 bariatric surgeries were reported, was examined. Concurrent panniculectomy procedures were identified by CPT codes. Patient characteristics and in-hospital as well as 30-day complications were compared between the body contouring group and propensity score–matched bariatric surgery controls. Overall, 124 patients met the inclusion criteria and were matched to 248 controls. An infraumbilical panniculectomy was performed in the majority of patients [n = 94 (75.8%)]. Most patients received an open rather than laparoscopic bariatric surgery [n = 87 (70.2%)]. There were no statistically significant differences between 30-day mortality (1.9%), wound complications (11.5%), readmission (12.5%), and reoperation (5.8%) between the two groups ($p > 0.05$). Wound complications occurred in 11.5% of patients and were associated with prolonged hospital stay (odds ratio, 4.65; 95% CI, 1.99-10.86; $p < 0.001$) and a body mass index (BMI) of > 50 kg/m^2 (odds ratio, 3.19; 95% CI, 1.02-9.96; $p = 0.046$). The authors concluded that in select patients, panniculectomy at the time of bariatric surgery was not associated with increased in-hospital or 30-day adverse outcomes compared with matched bariatric surgery controls; however, revision surgery may be needed once weight loss stabilizes. The study is limited by database limitations, short-term follow-up, and multiple outcome variables.

Nag et al. (2021) performed a retrospective cohort study and systematic review to evaluate the premise that the addition of panniculectomy to gynecologic surgery in the obese and morbidly obese population results in a statistically significant improvement in measurable outcomes. The American College of Surgeons National Surgical Quality Improvement Program (NSQIP) database was reviewed to assess the association of complications with panniculectomy combined with gynecologic surgery in the morbidly obese population. The query identified 296 individuals with a BMI of greater than 30 kg/m^2 who had panniculectomy concomitant with gynecologic surgery. The results demonstrated a statistically significant relationship ($p < 0.05$) of these concomitant procedures with superficial infection, wound infection, pulmonary embolism, systemic sepsis, return to operating room, length of operation, and length of stay. A systematic review of the literature was

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then performed, which identified only five studies that included comparative cohorts of those with gynecologic surgery, with and without panniculectomy. There was no significant benefit across the studies in measured parameters. The authors concluded that there was no statistically significant benefit associated with performing panniculectomy in conjunction with gynecologic surgery in the morbidly obese population and that there was significant elevation of negative outcomes in individuals with morbid obesity undergoing combined procedures.

Prodromidou et al. (2020) conducted a systematic review and meta-analysis to assess the safety and efficacy of combining panniculectomy with endometrial cancer (EC) surgery in obese women. Four electronic databases were systematically searched for articles published up to May 2019. Overall, five studies, of which two were noncomparative and three were comparative, were included. The two noncomparative studies included 33 individuals, while the remaining three comparative studies evaluated results in 65 individuals who received simultaneous laparotomy for EC and panniculectomy (panniculectomy group) vs 416 who underwent laparotomy only for EC (laparotomy group).The primary outcome was complication rates; the meta-analysis of complications among the panniculectomy and conventional laparotomy groups revealed no difference in either intra- or postoperative complication rates. Moreover, no difference was reported in surgical site complications ($p = 0.59$), while wound breakdown rates were significantly elevated in the laparotomy group ($p = 0.02$). The authors concluded that panniculectomy combined with surgery for the management of EC can be considered a safe procedure in selected individuals and presents with comparable outcomes to conventional laparotomy procedures regarding nonsurgical and surgical site complications and improved wound breakdown rates. The authors noted that the outcomes must be cautiously interpreted because of the limited number of studies included in this meta-analysis and the studies' retrospective nature.

Sosin et al. (2020) conducted a systematic meta-analysis to assess the durability, complication profile, and safety of simultaneous ventral hernia repair and panniculectomy (SVHRP) through a large, data-driven repository of SVHRP cases. The current SVHRP literature was queried using the MEDLINE, PubMed, and Cochrane databases. Predefined selection criteria resulted in 76 relevant titles, yielding 16 articles for analysis. A meta-analysis was used to analyze primary outcomes, identified as surgical site occurrence and hernia recurrence. The secondary outcomes included a review of techniques used and systemic complications, which were analyzed with a pooled weighted mean analysis from the collected data. There were 917 individuals who underwent an SVHRP (mean age, 52.2 ±7.0 years; mean BMI, 36.1 ±5.8 kg/m^2; mean pannus weight, 3.2 kg). The mean surgical site occurrence rate was 27.9% (95% CI, 15.6%-40.2%; I = 70.9%), and the mean hernia recurrence rate was 4.9% (95% CI, 2.4%-7.3%; I = 70.1%). The mean follow-up was 17.8 ±7.7 months. The most common complications were superficial surgical site infection (15.8%) and seroma formation (11.2%). Systemic complications were less common (7.8%), with a thromboembolic event rate of 1.2%. The overall mortality rate was 0.4%. The authors concluded that SVHRP is associated with a high rate of surgical site occurrence, but surgical site infection seems to be less prominent than previously anticipated. The authors indicated that the low hernia recurrence rate and safety of this procedure support its current implementation in abdominal wall reconstruction. (McNichols et al., 2018, previously cited in this policy, is included in this systematic review.)

Clinical Practice Guidelines

American Society of Plastic Surgeons (ASPS)

In a practice parameter, the ASPS (2017) notes that panniculectomy could be considered as a functional correction in patients who are of appropriate height and weight and have a history of problems, including panniculitis and chronic back pain, that have persisted despite an adequate trial of nonsurgical management or have a functional impairment, such as in activities of daily living/work. The ASPS notes a strong relationship between increased BMI and surgical complication across the surgical spectrum.

Society of Obstetricians and Gynaecologists of Canada (SOGC)

The SOGC clinical practice guideline for gynecologic surgery in patients with obesity (Yong et al., 2019) reviews the evidence for panniculectomy performed concurrently with gynecologic surgeries. The guideline notes that studies in this area have been primarily small, retrospective, and/or noncomparative. The authors indicate that panniculectomy can be considered at the time of open hysterectomy in patients with obesity, although it is rarely performed; when a combined procedure is done, consideration should be given to postoperative antibiotics.

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 are 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 January 20, 2026)

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Policy History/Revision Information

Date	Summary of Changes
07/01/2026	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version MP.014.27

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, check the member specific benefit plan document and any applicable federal or state mandates. 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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. 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.

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