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Subject: Cosmetic and Reconstructive Services of the Trunk, Groin, and Extremities

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Description/Scope

This document addresses a variety of surgical procedures of the trunk or groin that may be considered medically necessary, cosmetic or reconstructive in nature.

Note: Please see these documents for related topics:

- CG-SURG-12 Penile Prosthesis Implantation
- CG-SURG-71 Reduction Mammoplasty
- CG-SURG-88 Mastectomy for Gynecomastia
- SURG.00023 Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures

Note: For information regarding excision of excess abdominal skin, please see CG-SURG-99 Panniculectomy and Abdominoplasty.

Medically Necessary: In this document, procedures are considered medically necessary if there is a significant functional impairment AND the procedure can be reasonably expected to improve the functional impairment.

Reconstructive: In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect.

Note: Not all benefit contracts/certificates include benefits for reconstructive services as defined by this document. Benefit language supersedes this document.

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Cosmetic: In this document, procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those which are primarily intended to preserve or improve appearance.

Position Statement

A. Brachioplasty:

Brachioplasty is considered **medically necessary** when done in the presence of a significant functional impairment (for example, redundant or excessive skin is interfering with activities of daily living or causing persistent dermatitis, cellulitis, or skin ulcerations) and the impairment persists despite optimal medical management (for example, topical or systemic treatments for infection) and the procedure is reasonably expected to improve that significant functional impairment.

Brachioplasty is considered **cosmetic and not medically necessary** when done in the absence of a significant functional impairment or when not expected to improve a significant functional impairment.

B. Buttock/Thigh Lift:

Buttock or thigh lifts are considered **medically necessary** when there is a significant functional impairment (for example, redundant or excessive skin is interfering with activities of daily living or causing persistent dermatitis, cellulitis, or skin ulcerations) and the impairment persists despite optimal medical management (for example, topical or systemic treatments for infection) and the procedure is reasonably expected to improve that significant functional impairment.

Buttock and thigh lifts are considered **cosmetic and not medically necessary** when done in the absence of a significant functional impairment or when not expected to improve a significant functional impairment.

C. Congenital Abnormalities:

Correction of congenital abnormalities of the trunk and groin are considered **medically necessary** when there is evidence of a significant functional impairment and the procedure can be reasonably expected to improve the functional impairment.

Correction of congenital abnormalities of the trunk and groin that are a significant variation from normal are considered **reconstructive** in nature.

In the absence of a significant functional impairment or significant variation from normal, correction of congenital abnormalities is considered **cosmetic and not medically necessary**.

D. Lipectomy/Liposuction:

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Lipectomy or liposuction is considered **medically necessary** in individuals with documented *lymphedema* (primary or secondary, for example, related to surgical mastectomy) when *all* of the following criteria are met (1 through 5):

1. Signs and symptoms have not responded to at least 3 consecutive months of optimal medical management, including *one or more* of the following:
 - a. Compression garments; **or**
 - b. Manual lymph drainage; **or**
 - c. Complex/complete decongestive therapy (CDT);

and

2. For each anatomical region being considered for treatment, *either* of the following criteria are met:
 - a. There is documented significant functional impairment as a direct result of change in limb volume from lymphedema accumulation (for example, difficulty ambulating, performing activities of daily living, or loss of function coincident with the volume change); **or**
 - b. There are documented medical complication(s) as a result of lymphedema (for example, severe recurrent cellulitis or severe neurological symptoms [for example, numbness, tingling or paresthesia]), and *both* of the following criteria are met for the complication(s):
 - i. Not amenable to conservative management; **and**
 - ii. Significant enough to warrant surgical intervention;

and

3. Lipectomy or liposuction is reasonably expected to improve the functional impairment (for example, volume reduction of extremity circumferences is expected to result in a significant improvement in mobility); **and**
4. The plan of care is to wear compression garments as instructed and continue conservative treatment postoperatively to maintain benefits; **and**
5. Photographic documentation is consistent with the diagnosis of lymphedema in the affected extremities, including limb asymmetry.

Lipectomy or liposuction is considered **medically necessary** in individuals with *lipedema* when *all* of the following criteria are met (1 through 6):

1. A diagnosis of lipedema has been documented, including *all* of the following:
 - a. Bilateral, symmetrical, disproportionate fatty tissue hypertrophy on the limbs sparing the hands and feet; **and**
 - b. Negative Stemmer sign; **and**
 - c. Marked tendency to bruise or form hematomas; **and**
 - d. Stable limb circumference with weight reduction or caloric restriction (if applicable); **and**
 - e. Pain on pressure and touch;

and

2. Signs and symptoms have not responded to at least 3 consecutive months of optimal medical management, including *both* of the following:
 - a. Compression garments; **and**

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- b. Manual lymphatic drainage;
- and**
3. For each anatomical region being considered for treatment, *either* of the following criteria are met:
 - a. There is documented significant functional impairment as a direct result of change in limb volume from lipedema (for example, difficulty ambulating or performing activities of daily living); **or**
 - b. There are documented medical complication(s) as a result of lipedema (for example, severe aching discomfort, pain or tenderness, severe maceration, severe recurrent skin infection, or severe venous insufficiency) and *both* of the following criteria are met for the complication(s):
 - i. Not amenable to conservative management; **and**
 - ii. Significant enough to warrant surgical intervention;
- and**
4. Lipectomy or liposuction is reasonably expected to improve the functional impairment or medical complications (for example, volume reduction of extremity circumferences is expected to result in a significant improvement in mobility); **and**
5. The plan of care is to wear compression garments as instructed and continue conservative treatment postoperatively to maintain benefits; **and**
6. Photographic documentation is consistent with the diagnosis of lipedema in the affected extremities, including limb symmetry.

Correction of lymphedema (for example, related to surgical mastectomy) or lipedema using lipectomy or liposuction is considered **reconstructive** when done to address a significant variation from normal.

Lipectomy or liposuction is considered **cosmetic and not medically necessary** when the reconstructive criteria in this section are not met **or** when the medically necessary criteria in this section are not met [for each anatomical region being considered for treatment](#), including for treatment of obesity in the absence of a documented diagnosis of lymphedema or lipedema.

Notes: Please refer to:

- CG-SURG-99 Panniculectomy and Abdominoplasty for information regarding lipectomy and liposuction of the abdomen.
- SURG.00023 Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures for information regarding the Women's Health and Cancer Rights Act of 1998.

E. Pectus Excavatum/Carinatum:

Surgical repair of a significant *pectus excavatum* with either an open or a minimally invasive approach (Nuss procedure) is considered **reconstructive** for individuals with [either of the following](#):

1. [A Haller index \(pectus severity index\) of greater than or equal to 3.2; or](#)
2. [A Pectus Correction Index \(PCI, also referred to as the Correction Index\) of greater than or equal to 28%.](#)

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Surgical repair of a significant *pectus carinatum* is considered **reconstructive** for individuals with a Haller index (pectus severity index) of less than or equal to 2.0.

Surgical repair of *pectus excavatum* or *carinatum* is considered **cosmetic and not medically necessary** when the criteria above have not been met.

Note:

1. For *pectus excavatum* the Haller index is calculated by measuring the transverse diameter of the thorax between the internal rib margins, divided by the minimal antero-posterior depth as measured from the internal aspect of the sternum to the anterior cortex of the subjacent vertebral body.
2. For *pectus carinatum* the Haller index is calculated by measuring the transverse diameter of the thorax between the internal rib margins, divided by the antero-posterior depth as measured from the most anterior level of the sternum to the anterior cortex of the subjacent vertebral body.

F. Procedures on the Genitalia:

Procedures performed on genitalia when intended to address the sequelae of significant trauma, injury, disease, or congenital defect in the absence of a functional impairment, may be considered **reconstructive** in nature, including, but not limited to, surgical correction of ambiguous genitalia and buried penis

Procedures on the external genitalia intended to improve the appearance or enhance sexual performance are considered **cosmetic and not medically necessary** including, but not limited to, the following:

1. Labia minora reduction;
2. Labia major reshaping;
3. Clitoral reduction;
4. Hymenoplasty;
5. Pubic liposuction or lift;
6. Phalloplasty.

Vaginal rejuvenation or vaginal tightening procedures are considered **not medically necessary** under all circumstances.

Rationale

Concepts of Medical Necessity, Reconstructive and Cosmetic

The coverage eligibility of medical and surgical therapies to treat musculoskeletal abnormalities is often based on a determination of whether repair of the abnormality is considered medically necessary, reconstructive or cosmetic in nature. In many instances, the concept of reconstructive overlaps with the concept of medical necessity. For example, services intended to correct a significant functional impairment as a result of trauma will be considered medically necessary and thus eligible for coverage, regardless of the contract language pertaining to reconstructive

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services, unless some other exclusion applies. Generally, reconstructive is often taken to mean that the service, “Returns the person to whole,” as a result of a congenital anomaly, disease or other condition including post trauma or post therapy. Cosmetic generally describes improving a physical appearance that would be considered within normal human anatomic variation. Categories of conditions without associated functional impairment that may be included as reconstructive definitions, include or may be due to the following: a) surgery, b) accidental trauma or injury, c) diseases, d) congenital anomalies, e) severe anatomic variants, and f) chemotherapy.

Brachioplasty, Buttock/Thigh lift

Brachioplasty and buttock or thigh lifts have been proposed as a treatment for individuals with conditions related to excess skin and subcutaneous fat associated with significant functional impairment. Conditions, such as persistent infection or maceration resistant to conservative therapy, may be indications for brachioplasty, buttock lift or thigh lift when the condition poses a risk to the health of the individual.

Congenital abnormalities of the trunk and groin

Correction of a congenital abnormality, for example, ambiguous genitalia, congenital chordae [or corporal disproportion](#), hypospadias, penile torsion, or congenital buried or concealed penis, may be considered when the procedure is intended to address a significant variation from normal. [Procedures are also considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease \(for example, Peyronie’s disease\), trauma, or treatment of a disease.](#)

Pectus Excavatum and Carinatum

Validation of the medical necessity of surgical repair of pectus excavatum requires objective documentation of an associated functional impairment that is improved following surgical correction. In many cases, the motivation for surgical correction may be the restoration of a normal appearance. However, some individuals have reported associated cardiorespiratory symptoms, such as mild to moderate exercise limitation, respiratory infections or asthmatic symptoms. ~~Nevertheless, the published literature regarding pectus excavatum is dominated by articles focusing on the surgical technique; few articles have published studies that have included results of pre and postoperative cardiorespiratory function tests. In general, the available literature investigating significant objective functional limitations associated with pectus excavatum or significantly improved objective functional outcomes, as a result of corrective surgery, provides inadequate, controversial or conflicting data, which do not convincingly support surgical repair of pectus excavatum on functional grounds. Moreover, there is no evidence that the presence of pectus excavatum limits the life expectancy or the ability to perform any sort of occupation.~~

[A number of studies have evaluated the clinical impact of surgical correction of pectus excavatum on cardiac, pulmonary and other systems \(Kaguraoka, 1992; Haller, 2000; Morshuis, 1994a and 1994b; Shamberger, 2000\). These studies indicate that there is discordance between participants’ subjective assessment of improvement and objective measures of cardiorespiratory function. Some have suggested that discordance is due to the fact that](#)

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improvements in cardiorespiratory function can only be seen during periods of exercise, and thus are not detected during routine pulmonary function tests.

In a review article, Shamberger concluded that preoperative cardiopulmonary testing in subjects with pectus excavatum revealed a wide range of cardiopulmonary abnormalities, but since studies frequently did not report the degree of severity of the pectus excavatum or define controls, no generalizations could be made (Shamberger, 2000). Morshuis and colleagues (1994a) studied the pulmonary function in 152 subjects with pectus excavatum before and after surgical correction. Pulmonary function was abnormal preoperatively and may have been part of the motivation for surgery. However, multivariate analysis showed that preoperative pulmonary function was not related to age, the severity of the deformity at physical examination, or to pulmonary complaints. At follow-up (mean, 8.1 ± 3.6 years), the restriction of pulmonary function was increased despite improvement in the symptoms of most subjects and despite a significant increase in the anteroposterior diameter of the chest. Morshuis (1994b) reported on another case series of 35 subjects who underwent pulmonary function tests and exercise testing. Cardiorespiratory symptoms were present in almost all subjects before surgery; these symptoms either diminished or disappeared by 1 year post surgery. However, the results of the cardiorespiratory tests did not correlate with the clinical improvement. For example, all measures of pulmonary function decreased after surgery. The authors hypothesize that this decrease is related to postoperative restriction of the chest wall. After surgical repair, there was also a significant increase in the maximal oxygen uptake during exercise while the maximal work performance was unchanged. These findings suggest a less efficient cardiorespiratory function.

Kaguraoka and colleagues (1992) reported on a series of 138 subjects with pectus excavatum, correlating the degree of respiratory improvement with the severity of the deformity in the 22 who were available for postoperative assessment. There was mild respiratory impairment prior to surgery, as measured by a mean percent of predicted vital capacity (VC) of 86%. The severity of deformity was inversely related to the VC. Post surgery, the VC increased only slightly. Other respiratory parameters did not change. The authors concluded that surgical correction resulted in adequate cosmetic results but did not influence objective measures of respiratory function.

Peterson (1985) reported on the cardiovascular function of 13 subjects who underwent surgical repair of pectus excavatum. All subjects were symptomatic before surgery and showed a striking improvement post surgery. However, left ventricular ejection fraction and cardiac index, as measured by radionuclide studies at rest and during exercise, were normal both before and after surgery. There was an increase in ventricular volumes, suggesting that some degree of cardiac compression had been relieved by the surgical correction.

The above articles, which are representative of the literature on pectus excavatum, indicate that there is discordance between participants' subjective assessment of improvement and objective measures of cardiorespiratory function. Some have suggested that discordance is due to the fact that improvements in cardiorespiratory function can only be seen during periods of exercise, and thus are not detected during routine pulmonary function tests. Haller and colleagues (2000) studied 15 subjects before and after surgery for pectus excavatum and compared the results to age-matched controls. After surgery, individuals exercised longer and had a higher oxygen pulse than before surgery, whereas the non-surgical control group showed no such changes. Subjectively, 66% of subjects undergoing

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surgery reported improved exercise tolerance. The authors concluded that repair of pectus excavatum improved cardiorespiratory function during vigorous exercise.

Lawson and colleagues (2011) reported on the association of severity of pectus excavatum and the impact on pulmonary function. The authors concluded that individuals with pectus excavatum demonstrated an:

Increased depth of chest depression is related to an increased likelihood of below-normal pulmonary function, primarily with a restrictive pattern. Future studies should examine other measures in combination with depth of depression to increase our understanding of the mechanisms and impact of this deformity in cardiopulmonary function in both the resting and exercising states.

Zens (2022) reported the results of a case series study involving 345 participants that characterized the relationship between the degree of pectus excavatum and cardiopulmonary dysfunction. Symptoms were reported in 75% of participants, including shortness of breath, exercise intolerance, chest pain, and heart palpitations. Univariate analysis of cardiac systolic function revealed significant associations between all pectus indices measured and abnormal cardiac indications including right ventricular ejection fraction (RVEF) and RVEF Z-scores, including the Haller index and the Pectus Correction Index (PCI) ($p < 0.05$ for all). Univariate analysis of PFTs demonstrated associations ($p < 0.05$) with the Haller index and PCI, but not FEV1/FVC. The authors concluded that the severity of pectus excavatum is associated with ventricular systolic dysfunction and that pectus excavatum impacts right and left ventricular systolic function and can also impact exercise tolerance. They concluded that the Haller index and PCI may be the most useful predictors of impairment.

The severity of pectus excavatum may be assessed in several ways, but two methods have emerged as providing the most accuracy and utility (Sujka, 2018; Rodríguez-Granillo 2019). The Haller index is the most commonly used scale for the measurement of chest deformity in individuals with pectus excavatum. Many studies have used a cut-off point of 3.2 to determine the appropriateness of surgery, and this has become the accepted standard for most individuals undergoing pectus repair procedures (Croitoru, 2012; Lawson, 2011; Nuss, 1998; Nuss, 2002). While the Haller index remains standard of care, the PCI is also commonly used, as it remains accurate in individuals with abnormal chest wall morphologies (e.g., significant discrepancies of anterior-posterior to medial-lateral dimensions of the chest wall). Several studies have reported that a PCI result of 28% correlates with the long-accepted standard Haller index ≥ 3.25 as the threshold for operative repair for pectus excavatum, even in nonstandard chest morphologies (Poston, 2014; St Peter, 2011).

Other indices of the severity of pectus deformity have been proposed, including caliper-based external measurements (Chen, 2022), the Volumetric Correction Index (Trò, 2022), and the Titanic index (Bellía-Munzón, 2023). However, there is currently insufficient published evidence at this time to support their use in clinical care.

As with pectus excavatum, the measurement of pectus carinatum, also called pigeon chest, is commonly done using the Haller index. Although there is far less published data for this condition when compared to pectus excavatum, it

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has been widely accepted that a Haller index of 2.0 or less is a reasonable threshold for consideration of surgical correction of pectus carinatum (Fonkalsrud, 2006, 2004, 2002).

Regarding the surgical outcomes of a minimally invasive approach to correction, (that is, the Nuss procedure), initial results suggested a good to excellent outcome in the majority of individuals among those who have completed the treatment with subsequent removal of the steel bar (Nuss, 1998; Morshuis, 1994).

Lymphedema

Lymphedema is a debilitating progressive, incurable condition characterized by painful swelling of the extremities (arms and/or legs) but can affect any part of the body. The excessive swelling is the result of lymphatic stasis and accumulation in the subcutaneous tissue, due to a chronic imbalance between the production and drainage of lymph fluid. Primary lymphedema is a congenital condition; however, in the developed world, secondary lymphedema is the most common type of lymphedema and may be caused by infection, trauma or, most commonly, treatment of cancer. The resultant accumulation of lymph fluid in the tissues, usually of the extremities, produces painful disability and interferes with mobility and activities of daily living for affected individuals with varying degrees of severity. The onset of symptoms is subject to individual variation and can occur shortly after the insult, for example, following mastectomy, or can occur years later.

Physical examination has an important role in the diagnosis of lymphedema, including limb circumference and volume measurements. The calculation of limb volume can be estimated by taking serial circumferential measurements at standard distances along the affected limb, water displacement measurement, optoelectronic volumetry, or use of truncated cone formula calculation. These methods are recognized as reasonably accurate and are commonly available. According to a respected textbook on the subject of lymphedema, a volume increase of $\geq 10\%$ in the affected limb vs. the unaffected limb is indicative of the presence of lymphedema (Tidhar, 2022). Furthermore, the International Society of Lymphology (2020) defines “mild” lymphedema as a volume difference between the affected and contralateral limbs as greater than 10 percent but less than 40 percent.

First line conservative treatments for lymphedema include limb elevation, skin care, compression garments, manual lymph drainage and complex decompressive therapy (CDT). When conservative therapy is ineffective surgical options can be considered. These include reductive/ablative techniques, like liposuction and excisional lipectomy, for more advanced lymphedema where fat deposition and tissue fibrosis has occurred, resulting in significant functional impairment or serious complications, such as cellulitis. For advanced cases in which all conservative options have been exhausted, liposuction has been shown to safely restore function, as long as conservative therapy, (such as compression garments, elevation, and exercise), is maintained postoperatively.

In a descriptive study, Lamprou and colleagues (2017) reported on circumferential suction-assisted lipectomy (CSAL) for end-stage lymphedema (primary or secondary) of the lower extremity. The researchers included subjects that did not respond to conventional therapy and had a volume difference of at least 1500 ml between the affected and non-affected extremity or a relative volume difference of more than 15% of the unaffected extremity

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volume. Exclusion criteria included bilateral lymphedema, active malignancy, or persistent open wounds. A total of 88 subjects (47 with primary lymphedema and 41 with secondary lymphedema) were included. Lower extremity volume was measured before surgery and at 1, 6, 12, and 24 months postop. In the primary lymphedema group, the median preoperative volume difference between the affected and unaffected lower extremity was 3686 ml. At 2 years, the difference was reduced to 761 ml (79% reduction). In the secondary lymphedema group, the median preoperative volume difference between the affected and unaffected lower extremity was 3320 ml. At 2 years, the difference was reduced to -38 ml (101% reduction). Cellulitis attacks in the primary and secondary group were significantly reduced (8/year to 0.2/year and 6/year to 0.3/year, respectively). There was a significant relationship between preoperative volume difference and the eventual outcome after 2 years in both groups ($p < 0.001$). In addition, men with primary lymphedema had a significantly greater volume reduction than women (median 1629 versus 275 ml; $p < 0.001$). The researchers concluded that CSAL was effective for treating end-stage, non-pitting lymphedema of the lower extremity. However, postoperative physical therapy, weight control, and lifestyle changes are needed to maintain the benefits.

In a consecutive cohort study, Hoffner and colleagues (2017) evaluated health-related quality of life (HRQoL) following liposuction (combined with postop conservative therapy) for individuals with post-mastectomy upper extremity lymphedema. Between 1999 and 2013, the researchers gave 90 consecutive individuals a 36-item short-form health survey (SF-36) to fill out before liposuction and at 1, 3, 6, and 12 months postop. A total of 30 individuals did not answer all surveys and were excluded from the final cohort. Inclusion criteria included a minimum 10% increase in volume of the affected extremity compared to the non-affected side, subjective discomfort, failure of conservative treatment to reduce excess volume completely, and no or minimal pitting edema (less than 5mm). Exclusion criteria included generalized disease, local ulcers, and unwillingness or doubts about undergoing continuous conservative therapy after surgery. Lymphedema volume was measured by water displacement, and aspirate volumes were collected in 2000 ml canisters and measured within a 10 ml accuracy. The total aspirated volume was 1361 ± 66 ml, with fat volume totaling 1373 ± 56 ml. The mean \pm standard error of the mean (SEM) was reduced from 1365 ± 73 mL preoperatively to -213 ± 35 ml at 1-year follow-up. No minor or major complications were reported. In 49 individuals (82%), excess volume was completely reduced. After 1 year, SF-36 scores were significantly improved for functional impairments, bodily pain, vitality, social functioning and mental health. The authors concluded that liposuction combined with conservative therapy improves HRQoL. The study was limited by a small sample size.

In 2018, Hoffner and colleagues published a prospective study on the 5-year results of liposuction for arm lymphedema following breast cancer treatment. A total of 127 women received liposuction and conservative therapy between 1993 and 2012. A total of 105 women with non-pitting edema remained in the study after 27 were lost to follow-up, 18 died, 1 had recurrence of breast cancer, 1 stopped postoperative conservative treatment, 1 moved abroad, and 1 had missing data. The researchers used standardized forms to collect pre-, peri-, and post-operative data. Inclusion criteria included the diagnosis of secondary arm lymphedema following breast cancer treatment, significant excess volume at least 10% larger than the unaffected arm, discomfort, failure of conservative treatment to reduce the excess volume completely, and no or minimal pitting edema (less than 5 mm). Exclusion criteria included active cancer, wounds, infections, and unwillingness to undergo post-operative conservative

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therapy. The post-operative mean reduction at 5 years was $117\% \pm 26\%$ (range 25–191) as compared with the unaffected arm. There were no reported complications. The authors concluded that as long as post-operative conservative therapy is maintained, liposuction is effective for treating chronic, non-pitting arm lymphedema.

Lipedema

Lipedema is a painful, chronic, incurable disease that almost exclusively affects women after puberty and is characterized by abnormal bilateral enlargement of subcutaneous adipose tissue of the legs or arms but with normal hands and feet. The cause of lipedema is unknown, but evidence suggests it may be genetically inherited and triggered by hormonal changes, such as puberty, pregnancy, or menopause. The lymphatic system is not typically affected by lipedema; however, in severe cases, the lymphatic system can become overloaded and secondary lymphedema, (referred to as lipolymphedema or lympho-lipedema), can develop. In addition, advanced cases of lipedema can affect the venous system (venolipedema). The major symptoms are painful sensation in the involved limbs, impaired mobility and disfigurement with lipoma-like lumps under the skin. First line treatment is conservative, including complex decongestive therapy (CDT). CDT combines several approaches including manual lymph drainage (a massage technique), compression therapy, and physical mobilization. When symptoms persist and worsen, surgical options are considered. Although the condition is rare, there is some published evidence to support surgical treatment techniques, such as liposuction and excisional lipectomy. For individuals afflicted with lipedema, liposuction helps to reduce volume, inflammation and pain; restore or maintain mobility; slow disease progression; and has had a positive impact on the quality of life. However, there is no cure for lipedema, and ongoing postoperative conservative treatment is usually necessary to retain the benefits gained by liposuction.

According to the National Center for advancing translational sciences (NIH):

Classical guidelines for diagnosing lipedema include the following criteria: occurrence almost exclusively in women; bilateral and symmetrical presentation with minimal involvement of the feet; minimal pitting edema, pain, tenderness, and easy bruising, and persistent swelling of lower extremities despite elevation or weight loss. Updated guidelines propose a diagnosis of lipedema with the criteria as classically defined, in addition to symptoms of the upper leg(s) and arm(s), such as a circularly thickened layer of fat affecting the skin...Treatment for lipedema is focused on managing the symptoms. There is no one effective treatment for lipedema. Management to alleviate symptoms and prevent progression involves exercise, diet and nutrition, emotional support, and management of co-existing health problems that may cause leg-swelling. The main conservative treatment is CDT. Surgery may be considered if conservative and supportive therapies are not effective. Surgical options may include liposuction using specialized techniques for lipedema, (such as water jet-assisted liposuction) and excision (surgical removal of large deposits of affected tissue) (Bauer, 2019; Canning, 2018; Halk, 2017).

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Staging of lipedema is based on physical presentation of the disease focusing on the upper and lower extremities and does not take into account functional impact of disease such as pain, mobility, or impact on quality of life. According to the Lipedema Foundation and detailed by Herbst (2021), the stages of lipedema are defined as below:

- Stage 1: Smooth skin with an increase of enlarged subcutaneous fat tissue.
- Stage 2: Uneven skin with indentations in the fat tissue and larger mounds of fat tissue (lipomas) able to be seen and felt.
- Stage 3: Large extrusion of fat tissue causing deformations especially on the thighs and around the knees.
- Stage 4: Development of lipolymphedema - a condition where both Lipedema and lymphedema are present in the body - with large overhangs of tissue on legs and/or arms.

In 2019, Wollina and colleagues published a case series on liposuction for the treatment of lipedema (n=111; stage I=7, stage II=50, stage III=48). Participants were treated consecutively at a single center between 2007 and 2018. Most individuals were treated by micro-cannula liposuction in tumescent anesthesia, but some were treated with laser-assisted liposuction. Reduction of circumference was assessed using a tape measure. Pain was measured by a 10-point VAS, and mobility and reduction of bruising was evaluated using a 3-point scale. All participants had been treated with CDT for at least 6 months prior to surgery and had lipedema of the legs (27 individuals also had involvement of the arms). The mean follow-up was 2.0 ± 2.1 years. An improvement in the perception of mobility was achieved in all subjects; marked improvement or a complete reversal of impairment was reported in 86% of trial subjects. At follow-up, the median reduction of limb circumference was 6 cm. The median pain level before treatment was reduced from 7.8 to 2.2. Bruising after minor trauma improved somewhat in 20.9% of individuals and completely or almost completely in 29.1% of individuals. A total of 16.4% of individuals no longer needed CDT. For 18 individuals, a follow-up of 5-7 years was available and showed no relapse in lipedema. Common adverse events included temporary methemoglobinemia (100%), bruising (98%), and burning sensations (82%). Less common adverse events included mild arm-vein phlebitis (2 cases), noninfectious panniculitis (1 case), arm edema from toluidine blue extravasation (1 case), epileptic attack during methemoglobinemia (1 case), postsurgical anemia requiring a blood transfusion (1 case), pulmonary fat embolism 2 days after surgery (1 case), and acute pulmonary edema 24 hours after surgery (1 case). There were no fatalities, wound infections, or surgical interventions. In 4.5% of cases, liposuction was completed with other surgical procedures, such as thigh lifts, laser lipolysis, or debulking surgery. The authors concluded that an improvement of mobility could be achieved in all subjects and that liposuction is an effective treatment for painful lipedema. The authors also noted that centers performing liposuction should carefully monitor individuals for 24 hours and must be able to deal with possible complications.

Lymphedema vs. Lipedema

Lipedema is characterized by symmetric enlargement of the limbs, combined with tenderness and easy bruising. Unlike lymphedema, lipedema is not caused by a disorder of the lymphatic system. While lipedema always affects both legs symmetrically (bilateral appearance), primary lymphedema usually affects one leg only. If both legs are involved in primary lymphedema, the swelling appears asymmetric. The feet are not involved in lipedema; the symmetrical distribution of fat is located between the hips and the ankles. In contrast, the feet in lymphedema are

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involved in the swelling, and a diagnostic indicator known as the Stemmer sign* is positive. Lymphedema involves pitting edema, and the tissue feels firmer than what is present in lipedema. The cause for the onset of lymphedema is malformations of the lymphatic system, while the underlying cause of lipedema remains unknown and is thought to be associated with hormonal disorders.

There are several distinct differences between the presentation of lipedema and primary lymphedema which are part of the differential diagnosis process, and are provided in the table** below.

Lipedema	Lymphedema	Obesity
Disproportion present	Disproportion absent	Disproportion absent
Pubertal age of onset	Onset at any age	Onset at any age
Usually bilateral and mainly involving legs, but not feet	Uni- or bilateral, involving arms or legs	Usually bilateral, involving arms legs, including hands and feet
Skin color is normal, without pitting	Skin color is brown, warty, or sclerotic with pitting	Skin color is normal, without pitting
Stemmer sign negative	Stemmer sign positive	Stemmer sign negative
Skin consistency is firm	Skin consistency is soft	Skin consistency is soft
No response to compression therapy	Responds to compression therapy	No response to compression therapy
Easy bruising	Generally not bruising	Generally not bruising

** adapted from Shavit, 2018.

* The Stemmer Test is done by trying to lift a skin fold on the back of the second toe or middle finger. If you are able to gently pinch and lift the skin fold, the Stemmer Sign is negative. If it is not possible to gently pinch and lift the fold, this may be an indication of protein accumulation in the tissue. In this case, the Stemmer Sign is positive and serves as an indication that lymphedema may be present.

The term “hematoma” has been used in place of “bruising” by some authors when discussing the diagnosis of lipedema (Kruppa, 2020). This sign is due to capillary damage related to primary microvascular dysfunction in the lymphatic and blood capillaries that has been hypothesized to underly the pathophysiological basis for the formation of edema and bruising in individuals with lipedema.

Female Genital Procedures

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In 2020 the American College of Obstetricians and Gynecologists (ACOG) published a Committee Opinion, Elective Female Genital Cosmetic Surgery. This document addresses several important issues on this topic, including:

- Patients should be made aware that surgery or procedures to alter sexual appearance or function (excluding procedures performed for clinical indications, such as clinically diagnosed female sexual dysfunction, pain with intercourse, interference in athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence, or gender affirmation surgery) are not medically indicated, pose substantial risk, and their safety and effectiveness have not been established.
- Women should be informed about the lack of high-quality data that support the effectiveness of genital cosmetic surgical procedures and counseled about their potential complications, including pain, bleeding, infection, scarring, adhesions, altered sensation, dyspareunia, and need for reoperation.

ACOG (2022) has also published a statement of policy on the use of female genital mutilation. That document states the following:

Female genital mutilation (FGM), sometimes annotated as female genital cutting or female circumcision, is described by the World Health Organization (WHO) as comprising “all procedures that involve partial or total removal of the external female genitals, or other injury to the female genital organs for non-medical reasons (1,2).” Although these procedures are more commonly performed in Africa, the Middle East, and Asia, it is estimated that more than 513,000 girls and women in the U.S. have experienced or are at risk of FGM (3,4). People may arrive in the U.S. having already had the procedure performed, but there are reports of these procedures being performed in immigrant populations by traditional practitioners, or children being sent to the family’s home country to have the procedures performed.

Female genital mutilation is internationally recognized as a human rights violation and is considered an extreme form of discrimination against women (1,2). According to U.S. federal law (18 U.S. Code § 116), it is illegal to perform FGM in the U.S. on anyone under the age of 18 years; it is also illegal to knowingly transport a girl out of the U.S. for the purpose of having FGM performed. Many state laws also prohibit FGM on minors, and some states prohibit the practice on adult women. The American College of Obstetricians and Gynecologists condemns the practice of FGM and supports all efforts to eliminate the practice of FGM in the U.S. as well as internationally. This position is aligned with those of the World Health Organization, the American Medical Association, and the American Academy of Family Physicians (1,2,5,6).

In 2017 ACOG published a Committee Opinion for Breast and Labial Surgery in Adolescents which has guidance on the topic. Specifically, the following:

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- When adolescents seek medical treatment, the first step is often education and reassurance regarding normal variation in anatomy, growth, and development.
- Appropriate patient counseling and assessment of the adolescent's physical maturity and emotional readiness are necessary before surgical management or referral.
- Individuals should be screened for body dysmorphic disorder. If an obstetrician- gynecologist suspects an adolescent has body dysmorphic disorder, referral to a mental health professional is appropriate.

Surgical correction (labiaplasty) in girls younger than 18 years should be considered only in those with significant congenital malformation, or persistent symptoms that the physician believes are caused directly by labial anatomy, or both. Physicians should be aware that surgical alteration of the labia that is not necessary to the health of the adolescent, who is younger than 18 years, is a violation of federal criminal law 10. At least half of the states also have laws criminalizing labiaplasty under certain circumstances, and some of these laws apply to minors and adults. Obstetrician-gynecologists should be aware of federal and state laws that affect this and similar procedures.

Several laser devices have been marketed to tighten lax vaginal anatomy. The safety and efficacy of these laser systems has not been demonstrated in clinical trials with peer-reviewed published evidence for the indication of vaginal atrophy. The U.S. Food and Drug Administration (FDA) has issued a warning about use of these energy-based devices as follows:

To alert patients and health care providers that the use of energy-based devices to perform vaginal "rejuvenation," cosmetic vaginal procedures, or non-surgical vaginal procedures to treat symptoms related to menopause, urinary incontinence, or sexual function may be associated with serious adverse events. The safety and effectiveness of energy-based devices for treatment of these conditions has not been established...The FDA has not cleared or approved any energy-based medical device for vaginal "rejuvenation" or vaginal cosmetic procedures, or for the treatment of vaginal symptoms related to menopause, urinary incontinence, or sexual function (FDA, 2018).

Background/Overview

Brachioplasty is a surgical procedure used to remove excess fat and skin from the back of the upper arm. This procedure is done primarily to improve an individual's appearance. However, when associated with significant functional impairment, this procedure may be necessary to protect the individual's health.

Buttock and thigh lifts are surgical procedures used to remove excess fat and skin from the buttocks and thighs. These procedures are primarily intended to enhance the appearance and have no known medical benefits, although these procedures may be necessary when the excessive tissue presents a significant functional impairment despite optimal medical management.

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Congenital abnormalities in children include a wide variety of physical abnormalities present at birth. In many cases, the abnormality is not associated with any functional impairment. However, its correction can be considered reconstructive in nature. In most severe cases, immediate surgical care is needed to save a child's life.

Cosmetic surgery is defined as any surgical procedure conducted solely to enhance an individual's appearance. Such surgical procedures have no impact on an individual's physical health.

Liposuction, (also known as lipoplasty, suction-assisted lipectomy, circumferential suction-assisted lipectomy [CSAL], liposuction in lymphedema and lympho-liposuction), is a surgical procedure performed to recontour the individual's body by removing excess fat deposits that have been resistant to reduction by diet or exercise. There are multiple techniques for performing liposuction, including gentler methods like tumescent, power-assisted, ultrasound-assisted, laser-assisted, and water-jetted liposuction. These procedures have been used successfully on many body locations, including the buttocks, thighs, chin and lower abdomen, while they do remove large quantities of fat, they are not intended as a weight reduction technique. Liposuction is also used to treat advanced symptomatic lymphedema when there is a significant variation from normal, such as of the breast related to surgical mastectomy.

Excisional lipectomy, (also referred to as longitudinal debulking excisional surgery), is another surgical technique that involves the invasive surgical removal of excess subcutaneous adipose tissue that accumulates as a result of lipedema or lymphedema. Excisional lipectomy has been used to treat advanced cases with large localized deposits of lipedematous tissue, serious mechanical difficulties, valgus deformity of the knees, or the inability to walk (Halk, 2017).

Pectus excavatum, also known as funnel chest, is the most common chest wall deformity; this abnormality is present at birth, consisting of a depression in the center of the chest over the sternum. It is caused by excessive growth of the cartilage (connective tissue) joining the ribs to the breastbone, with the result being an inward deformity of the sternum. Although it has been proposed that pectus excavatum can be associated with various cardiopulmonary dysfunctions, this relationship has not been confirmed in the published literature. Until recently surgical correction of pectus excavatum involved the resection of the involved costal cartilages and osteotomy of the sternum with placement of a metal bar behind the sternum. The metal bar may be removed in 1 to 2 years. In the past several years, a minimally invasive approach has been developed that involves the placement of a convex steel bar beneath the sternum through small bilateral thoracic incisions. The bar may be removed after 2 years when remodeling of the cartilage is complete. This procedure, which may be referred to as the Nuss procedure or MIRPE (minimally invasive repair of pectus excavatum) does not require cartilage resection or sternal osteotomy. The degree of deformity in individuals with this condition is commonly measured using the Haller index or the Pectus Correction Index (PCI, also referred to as the Correction Index). Both indices are calculated using chest dimension measurements obtained with computed tomography (CT scan) or magnetic resonance imaging (MRI). A Haller Index of at least 3.2 is generally recognized to indicate a pectus excavatum of sufficient severity to

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consider surgical repair. [Similarly, a PCI of greater than or equal to 28% indicates a pectus excavatum of sufficient severity to consider surgical repair.](#)

Pectus carinatum is the second most common congenital chest wall deformity, a condition where the breastbone protrudes out from the chest, often described as giving the person a bird-like appearance. Pectus carinatum may occur as a solitary abnormality or in association with other genetic disorders or syndromes. Although it has been proposed that pectus carinatum can be associated with various cardiopulmonary dysfunctions, this relationship has not been confirmed in the published literature. As with PE, the degree of deformity is measured using the Haller index. A Haller Index of 2.0 or less is generally recognized to indicate a pectus carinatum of sufficient severity to consider surgical repair.

A wide variety of procedures have been proposed to alter the appearance, size, or function of the external and internal vaginal anatomy. Surgical procedures to alter the size or shape of the labia or clitoris, restore the hymen, and other such measures do not provide any physical health benefits.

The labia minora is part of the external structure of the vagina. In some individuals, the labia minora may be enlarged or asymmetrical leading to mild discomfort with wearing certain clothing or during some activities. Reconstructive surgical procedures have been proposed to reduce enlarged labia minora. These procedures have not been well studied in the medical literature, and the possible risks they present have not been adequately assessed in relation to the potential benefits. In addition, fractional carbon dioxide (CO₂) lasers are new non-surgical treatments purported to relieve vulvovaginal atrophy. This laser therapy is proposed as a means of delivering thermal energy to the vaginal walls resulting in thickening and tightening to improve vaginal atrophy. One such device is the MonaLisa Touch® (Cynosure, Hologic, Inc. Marlborough, MA), which is a CO₂ laser system which is performed in several sessions in the provider's office and promoted as a treatment for the symptoms of vaginal atrophy.

Phalloplasty is a surgical procedure to reconstruct or enlarge the penis. Reconstruction may be required in cases of traumatic injury or loss due to disease, in the absence of a functional impairment. Enlargement may be desired in cases of abnormally small penis size.

[Perineoplasty is a procedure intended to correct injury, defect or trauma of the of perineum or vulva; it is commonly used as a part of vaginal tightening procedures \(Triana, 2022\). Perineoplasty may also be a component of procedures addressing cystocele, and retrocele, or prolapse of the vagina or colon, with use intended to address a significant variation from normal.](#)

Definitions

Cellulitis: An infection that spreads to deep tissues of the skin and muscle and may cause warmth, tenderness, fever, chills, swollen lymph nodes, and blisters.

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Medical Policy

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Complex decongestive therapy: A multimodality program that consists of manual lymphedema drainage therapy, low-stretch bandaging, exercises, and skin care. This approach has been recommended as a primary treatment by consensus panels and as an effective therapy for lymphedema when it is unresponsive to standard elastic compression therapy.

Excisional lipectomy: A surgical technique that involves the invasive surgical removal of excess subcutaneous adipose tissue that accumulates as a result of lipedema or lymphedema.

Functional impairment: Significant functional impairment may include physical, social, emotional, and psychological impairments or potential impairments. Examples of limits on normal physical functioning include problems with: ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts, or obstruction of an orifice. The cause of a functional impairment can be due to pain, structural integrity, congenital anomalies or other factors.

Haller index (pectus severity index or PSI): One measure of the severity of a pectus deformity that compares the ratio of the transverse diameter of the chest between the internal rib margins divided by the minimal antero-posterior depth as measured from the internal aspect of the sternum to the anterior cortex of the subjacent vertebral body, at the point of maximal depression. In individuals with pectus excavatum a Haller Index of at least 3.2 is generally recognized to indicate a pectus excavatum PE of sufficient severity to consider surgical repair. In individuals with pectus carinatum-, a Haller Index of 2.0 or less is generally recognized to indicate a pectus carinatum of sufficient severity to consider surgical repair.

Lipedema: A chronic disease affecting almost exclusively women after puberty, characterized by painful abnormal enlargement of subcutaneous adipose tissue of the arms and legs.

Lymphatic fluid: A clear fluid that contains white blood cells (lymphocytes) and plasma.

Lymph nodes: Small, bean-shaped structures, found in the axilla, pelvis, neck, abdomen, and groin, that filter lymphatic fluid and store white blood cells.

Lymphatic system: A network of lymph vessels, tissues, and organs that carry lymphatic fluid throughout the body and return it to the bloodstream.

Lymphedema: Abnormal accumulation of interstitial fluid and fibro-adipose tissues resulting from injury, infection, or congenital abnormalities of the lymphatic system.

Lymphoscintigraphy test: A test to evaluate the presence of lymphedema involving the use of small amounts of radioactive material called a radiotracer. The radiotracer is introduced into the skin where it travels through the area being examined. Radioactive energy from the radiotracer is detected by a special camera to create images which are used to identify the presence or absence of lymphatic disease.

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Liposuction also known as lipoplasty or suction-assisted lipectomy: A surgical technique performed to recontour the individual's body by removing excess fat deposits that have been resistant to reduction by diet or exercise.

Pectus correction index (PCI): One measure of the severity of a pectus deformity. It is calculated by measuring, on the same slice of CT image, the minimal antero-posterior depth as measured from the internal aspect of the sternum to the anterior cortex of the subjacent vertebral body (A), and the maximum distance between inner margin of the most anterior portion of the ribcage and the anterior vertebrae (B), and then using this equation: $PCI = 100 \times (B - A) / B$. A PCI of ≥ 28 percent is correlated with Haller index of ≥ 3.25 , and is recognized as a threshold for surgical correction for pectus excavatum.

Stemmer sign: A physical examination used to diagnose lymphedema involving the examiner pinching the skin of the dorsum of the foot or hand. The inability to pinch the skin of the dorsum of the foot or hand is a positive finding of the presence of lymphedema.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Procedures for excessive skin and subcutaneous tissue, lipectomy and liposuction (includes brachioplasty, buttock/thigh lifts)

Note: see SURG.00023 Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures for information regarding the Women's Health and Cancer Rights Act of 1998.

When services may be Medically Necessary when criteria are met:

CPT

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
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy), other area
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

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ICD-10 Procedure

0JBD0ZZ-0JBF3ZZ	Excision of upper arm subcutaneous tissue and fascia, right or left, open or percutaneous approach [includes codes 0JBD0ZZ, 0JBD3ZZ, 0JBF0ZZ, 0JBF3ZZ]
0JBG0ZZ-0JBH3ZZ	Excision of lower arm subcutaneous tissue and fascia, right or left, open or percutaneous approach [includes codes 0JBG0ZZ, 0JBG3ZZ, 0JBH0ZZ, 0JBH3ZZ]
0JD70ZZ-0JD73ZZ	Extraction of back subcutaneous tissue and fascia [by approach; includes codes 0JD70ZZ, 0JD73ZZ]
0JD90ZZ-0JD93ZZ	Extraction of buttock subcutaneous tissue and fascia, open or percutaneous approach [includes codes 0JD90ZZ, 0JD93ZZ]
0JDB0ZZ-0JDB3ZZ	Extraction of perineum subcutaneous tissue and fascia [by approach; includes codes 0JDB0ZZ-0JDB3ZZ]
0JDC0ZZ-0JDC3ZZ	Extraction of pelvic region subcutaneous tissue and fascia, open or percutaneous approach [includes codes 0JDC0ZZ, 0JDC3ZZ]
0JDD0ZZ-0JDF3ZZ	Extraction of upper arm subcutaneous tissue and fascia, right or left, open or percutaneous approach [includes codes 0JDD0ZZ, 0JDD3ZZ, 0JDF0ZZ, 0JDF3ZZ]
0JDG0ZZ-0JDK3ZZ	Extraction of lower arm and hand subcutaneous tissue and fascia, right or left, open or percutaneous approach [includes codes 0JDG0ZZ, 0JDG3ZZ, 0JDH0ZZ, 0JDH3ZZ, 0JDJ0ZZ, 0JDJ3ZZ, 0JDK0ZZ, 0JDK3ZZ]
0JDL0ZZ-0JDM3ZZ	Extraction of upper leg subcutaneous tissue and fascia, right or left, open or percutaneous approach [includes codes 0JDL0ZZ, 0JDL3ZZ, 0JDM0ZZ, 0JDM3ZZ]
0JDN0ZZ-0JDR3ZZ	Extraction of lower leg or foot subcutaneous tissue and fascia [right or left, by approach; includes codes, 0JDN0ZZ, 0JDN3ZZ, 0JDP0ZZ, 0JDP3ZZ, 0JDQ0ZZ, 0JDQ3ZZ, 0JDR0ZZ, 0JDR3ZZ]
0J070ZZ-0J073ZZ	Alteration of back subcutaneous tissue and fascia, open or percutaneous approach [includes codes 0J070ZZ, 0J073ZZ]
0J090ZZ-0J093ZZ	Alteration of buttock subcutaneous tissue and fascia, open or percutaneous approach [includes codes 0J090ZZ, 0J093ZZ]
0J0D0ZZ-0J0F3ZZ	Alteration of upper arm subcutaneous tissue and fascia [right or left, by approach; includes codes 0J0D0ZZ, 0J0D3ZZ, 0J0F0ZZ, 0J0F3ZZ]
0J0G0ZZ-0J0H3ZZ	Alteration of lower arm subcutaneous tissue and fascia [right or left, by approach; includes codes 0J0G0ZZ, 0J0G3ZZ, 0J0H0ZZ, 0J0H3ZZ]
0J0L0ZZ-0J0M3ZZ	Alteration of subcutaneous tissue and fascia, upper leg [right or left, by approach; includes codes 0J0L0ZZ, 0J0L3ZZ, 0J0M0ZZ, 0J0M3ZZ]
0J0N0ZZ-0J0P3ZZ	Alteration of lower leg subcutaneous tissue and fascia [right or left by approach; includes codes 0J0N0ZZ, 0J0N3ZZ, 0J0P0ZZ, 0J0P3ZZ]

ICD-10 Diagnosis

E65	All diagnoses, including but not limited to the following: Localized adiposity
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E88.2	Lipomatosis, not elsewhere classified
I89.0	Lymphedema, not elsewhere classified
I97.2	Postmastectomy lymphedema syndrome [see Note regarding WHCRA]
I97.89	Other postprocedural complications and disorders of the circulatory system, not elsewhere classified [post-surgical lymphedema]
Q82.0	Hereditary lymphedema

When services may be Reconstructive when criteria are met:

Note: for criteria for breast reconstructive procedures, see SURG.00023.

CPT

15877	Suction assisted lipectomy; trunk
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ICD-10 Procedure

0J060ZZ-0J063ZZ	Alteration of chest subcutaneous tissue and fascia [by approach; includes codes 0J060ZZ, 0J063ZZ]
0JD60ZZ-0JD63ZZ	Extraction of chest subcutaneous tissue and fascia [by approach; includes codes 0JD60ZZ, 0JD63ZZ]

ICD-10 Diagnosis

N65.0-N65.1	Deformity and disproportion of reconstructed breast
Z42.1	Encounter for breast reconstruction following mastectomy
Z85.3	Personal history of malignant neoplasm of breast
Z90.10-Z90.13	Acquired absence of breast and nipple

When services are Cosmetic and Not Medically Necessary:

For the procedure codes listed above when medical necessity or reconstructive criteria are not met.

When services are also Cosmetic and Not Medically Necessary:

For the following procedure codes:

ICD-10 Procedure

0Y0007Z-0Y0147Z	Alteration of buttock with autologous tissue substitute [right or left, by approach; includes codes 0Y0007Z, 0Y0037Z, 0Y0047Z, 0Y0107Z, 0Y0137Z, 0Y0147Z]
0Y000JZ-0Y014JZ	Alteration of buttock with synthetic substitute [right or left, by approach; includes codes 0Y000JZ, 0Y003JZ, 0Y004JZ, 0Y010JZ, 0Y013JZ, 0Y014JZ]
0Y000KZ-0Y014KZ	Alteration of buttock with nonautologous tissue substitute [right or left, by approach; includes codes 0Y000KZ, 0Y003KZ, 0Y004KZ, 0Y010KZ, 0Y013KZ, 0Y014KZ]
0Y000ZZ-0Y014ZZ	Alteration of buttock [right or left, by approach; includes codes 0Y000ZZ, 0Y003ZZ, 0Y004ZZ, 0Y010ZZ, 0Y013ZZ, 0Y014ZZ]

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Cosmetic and Reconstructive Services of the Trunk, Groin, and Extremities

ICD-10 Diagnosis

All diagnoses

Repair of Pectus Excavatum or Pectus Carinatum

When services may be Reconstructive when criteria are met:

CPT

21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy

ICD-10 Procedure

0PS000Z-0PS040Z	Reposition sternum with rigid plate internal fixation device [by approach; includes codes 0PS000Z, 0PS030Z, 0PS040Z]
0PS004Z-0PS044Z	Reposition sternum with internal fixation device [by approach, includes codes 0PS004Z, 0PS034Z, 0PS044Z]
0WU80JZ	Supplement chest wall with synthetic substitute, open approach
0WU84JZ	Supplement chest wall with synthetic substitute, percutaneous endoscopic approach

ICD-10 Diagnosis

E64.3	Sequelae of rickets
M95.4	Acquired deformity of chest and rib
Q67.6	Pectus excavatum
Q67.7	Pectus carinatum

When services are Cosmetic and Not Medically Necessary:

For the procedure codes listed above, when reconstructive criteria are not met.

Procedures on genitalia

When services may be Reconstructive or Cosmetic and Not Medically Necessary based on criteria:

CPT

54360	Plastic operation on penis to correct angulation
54440	Plastic operation on penis for injury
55899	Unlisted procedure, male genital system [when specified as phalloplasty]
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57291	Construction of artificial vagina, without graft

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57292	Construction of artificial vagina, with graft
57335	Vaginoplasty for intersex state

ICD-10 Procedure

0UBJZZ	Excision of clitoris, external approach
0UMK0ZZ-0UMK4ZZ	Reattachment of hymen [by approach; includes codes 0UMK0ZZ, 0UMK4ZZ]
0UQG0ZZ-0UQG4ZZ	Repair vagina [by approach; includes codes 0UQG0ZZ, 0UQG3ZZ, 0UQG4ZZ, 0UQG7ZZ, 0UQG8ZZ, 0UQG9ZZ]
0UQJ0ZZ-0UQJ4ZZ	Repair clitoris [by approach; includes codes 0UQJ0ZZ, 0UQJ4ZZ]
0UQK0ZZ-0UQK4ZZ	Repair hymen [by approach; includes codes 0UQK0ZZ, 0UQK3ZZ, 0UQK4ZZ, 0UQK7ZZ, 0UQK8ZZ, 0UQK9ZZ]
0UQM0ZZ-0UQM4ZZ	Repair vulva [by approach; includes codes 0UQM0ZZ, 0UQM4ZZ]
0UTJZZ	Resection of clitoris, external approach
0UTMZZ	Resection of vulva, external approach
0VUS0ZZ-0VUS4ZZ	Supplement penis with autologous tissue substitute [by approach; includes codes 0VUS0ZZ, 0VUS4ZZ]
0VUS5ZZ-0VUS9ZZ	Supplement penis with nonautologous tissue substitute [by approach; includes codes 0VUS5ZZ, 0VUS9ZZ]
0W0M0ZZ-0W0M4ZZ	Alteration of male perineum with autologous tissue substitute [by approach; includes codes 0W0M0ZZ, 0W0M4ZZ]
0W0M5ZZ-0W0M9ZZ	Alteration of male perineum with synthetic substitute [by approach; includes codes 0W0M5ZZ, 0W0M9ZZ]
0W0N0ZZ-0W0N4ZZ	Alteration of male perineum with nonautologous tissue substitute [by approach; includes codes 0W0N0ZZ, 0W0N4ZZ]
0W0N5ZZ-0W0N9ZZ	Alteration of male perineum [by approach; includes codes 0W0N5ZZ, 0W0N9ZZ]
0W0O0ZZ-0W0O4ZZ	Alteration of female perineum with autologous tissue substitute [by approach; includes codes 0W0O0ZZ, 0W0O4ZZ]
0W0O5ZZ-0W0O9ZZ	Alteration of female perineum with synthetic substitute [by approach; includes codes 0W0O5ZZ, 0W0O9ZZ]
0W0P0ZZ-0W0P4ZZ	Alteration of female perineum with nonautologous tissue substitute [by approach; includes codes 0W0P0ZZ, 0W0P4ZZ]
0W0P5ZZ-0W0P9ZZ	Alteration of female perineum [by approach; includes codes 0W0P5ZZ, 0W0P9ZZ]

ICD-10 Diagnosis

All diagnoses

When services are Not Medically Necessary

CPT

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58999

Unlisted procedure, female genital system (nonobstetrical) [when specified as any vaginal rejuvenation or tightening procedure for atrophy, including laser procedures such as MonaLisa Touch]

ICD-10 Diagnosis

All diagnoses

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Lymphedema
Lympho-Liposuction
MonaLisa Touch Laser
Pectus Carinatum
Pectus Excavatum
Phalloplasty
Suction-assisted Lipectomy
Thigh

The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

Document History

Status	Date	Action
Revised	05/09/2024	Medical Policy & Technology Assessment Committee (MPTAC) review. Added “for each anatomical region being considered for treatment” to lipectomy or liposuction NMN statement. Added Pectus Correction Index to pectus excavatum MN statement. Revised Rationale, Background, Definitions, References, and Websites sections.
Revised	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Revised MN criteria for lipectomy or liposuction for lymphedema and lipedema related to functional impairment or medical complications. Revised clinical indications section with minor typographical updates. Reformatted Clinical Indications section. Revised Description/Scope, Rationale, Background, References, and Websites sections.
Revised	08/10/2023	MPTAC review. Revised title to include “Extremities”. Revised position statements regarding lipectomy or liposuction for lymphedema and lipedema. Revised Rationale, References, and Websites sections.
Reviewed	05/11/2023	MPTAC review. Updated Rationale and References sections.
Revised	05/12/2022	MPTAC review. The example of buried penis was added to the Reconstructive statement for procedures on the genitalia. The Rationale and References sections were updated.
Revised	05/13/2021	MPTAC review. Removed the word, “Physical” in the term, “Functional impairment” in the Position Statement section. Revised the reconstructive statement for genitalia to add congenital defects. Updated the Rationale, Definitions and References sections.
	04/07/2021	Revised MN definition text in the Description section to remove the word, “Physical” in the term, “Functional impairment.” Removed same in the

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Cosmetic and Reconstructive Services of the Trunk, Groin, and Extremities

		Rationale and Background sections and clarified the Definition of 'Functional impairment' in the Definitions section.
Revised	11/05/2020	MPTAC review. A reconstructive statement has been added to the Position Statements. The Background, Index and References were updated. Updated Coding section; added codes 55899, 58999.
Revised	11/07/2019	MPTAC review. Criteria for liposuction and lipectomy were expanded to add MN indications and Reconstructive indications beyond breast cancer. The Rationale, Background, Definitions, Coding, and Index sections were updated.
Reviewed	01/24/2019	MPTAC review. References were updated.
Reviewed	02/27/2018	MPTAC review. The document header wording was updated from "Current Effective Date" to "Publish Date." References were updated.
Reviewed	02/02/2017	MPTAC review. Updated References section.
Revised	02/04/2016	MPTAC review. Revised cosmetic and not medically necessary statement to address procedures on external genitalia. Revised reconstructive statement to addressing genitalia. Removed ICD-9 codes from Coding section.
Reviewed	08/06/2015	MPTAC review. Updated References.
Reviewed	08/14/2014	MPTAC review. References and Websites updated.
Revised	08/08/2013	MPTAC review. Clarified note that defines how Haller index is measured for pectus excavatum and pectus carinatum. Updated Background and Websites.
Revised	08/09/2012	MPTAC review. Clarified medically necessary statement for brachioplasty. Added medically necessary statement for buttock & thigh lift. Added reconstructive statement for lipectomy/liposuction when done to address significant variant from normal directly related to surgical mastectomy. Clarified cosmetic and not medically necessary statements for buttock & thigh lift and lipectomy/liposuction. Rationale, Background, Coding, Websites and References sections updated.
Reviewed	05/10/2012	MPTAC review. Websites and References sections updated.
Reviewed	05/19/2011	MPTAC review. References and websites updated.
Reviewed	05/13/2010	MPTAC review. References and websites updated.
Reviewed	05/21/2009	MPTAC review. References updated.
Revised	05/15/2008	MPTAC review. Added reconstructive criteria for pectus excavatum and for pectus carinatum. Added cosmetic and not medically necessary statement for pectus excavatum and for pectus carinatum. Updated Reference section.
Revised	11/29/2007	MPTAC review. Added medically necessary statement to Brachioplasty section when significant physical functional impairment is present. Added reconstructive statement for congenital abnormalities. Changed not medically necessary statement for congenital abnormalities to be cosmetic/not medically necessary. Revised wording in Lipectomy/liposuction section to add "for all indications, including but not limited to the removal of excess fat from the thighs, buttocks, chest or abdomen." The phrase "cosmetic/not medically

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		necessary” was clarified to read “cosmetic and not medically necessary.” Updated coding and reference section.
Reviewed	03/08/2007	MPTAC review. No change to position statement. Updated reference section.
Revised	03/23/2006	MPTAC review. Added clarification and references regarding physiological impairment associated with pectus excavatum.
Revised	12/01/2005	MPTAC review. Added procedures of male and female genitalia.
	11/22/2005	Added reference for Centers for Medicare and Medicaid Services (CMS) – National Coverage Determination (NCD).
Revised	09/22/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.	06/16/2003	ANC.00009	Cosmetic and Reconstructive Services of the Trunk and Groin
WellPoint Health Networks, Inc.	04/28/2005	3.01.25	Surgical Treatment of Pectus Excavatum
	09/23/2004		Clinical Guideline: Liposuction

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