

PHP_7.04		Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti	
Original Policy Date:	December 1, 2025	Effective Date:	June 1, 2026
Section:	7.0 Surgery	Page:	Page 1 of 15

State Guidelines

Applicable Medi-Cal guidelines as of the publication of this policy ([this guideline supersedes the criteria in the Policy Statement section below](#)):

- I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:
 - N/A
- II. Department of Health Care Services (DHCS) Provider Manual Guideline:
 - [TAR and Non-Standard Benefits List: Codes 10000 thru 19999 \(tar and non cdI\)](#)

The codes listed on the policy are included in the above Provider Manual; however, there are no specific clinical guidelines.

- III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:
 - N/A

NOTE: Refer to [Appendix A](#) to see the state guidelines/policy statement changes (if any) from the previous version.

Policy Statement

[Any criteria that are not specifically addressed in the above Provider Manual, please refer to the criteria below.](#)

Panniculectomy Standard Criteria

- I. Panniculectomy may be considered **medically necessary** when **both** of the following are met:
 - A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease
 - B. Documentation to support **either** of the following:
 1. For restoration of normal **appearance** when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs)
 2. For restoration of normal **function**. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances

Panniculectomy After Weight Loss

- II. Panniculectomy, **after weight loss**, may be considered **medically necessary** when **all** of the following are met:
 - A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease
 - B. Documentation to support **either** of the following:
 - 1. For restoration of normal **appearance** when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs)
 - 2. For restoration of normal **function**. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances
 - C. Documentation of **either** of the following:
 - 1. For non-surgical weight loss, maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight)
 - 2. If weight loss is the result of bariatric surgery, twelve months must pass after bariatric surgery before panniculectomy is performed and only when weight has been stable for at least six months

Abdominoplasty

- III. Abdominoplasty may be considered **medically necessary** when **both** of the following are met:
 - A. There is documentation of a **significant structural abnormality of the abdominal musculature** caused by a congenital defect, development abnormality, trauma, infection, tumors or disease
 - B. The purpose of the procedure is to **either**:
 - 1. Create a normal appearance to the extent possible
 - 2. Improve function

Diastasis Recti Repair

- IV. Repair of diastasis recti (alone or in combination with another abdominal procedure) is considered **not medically necessary** for all indications.

Other Indications for Panniculectomy or Abdominoplasty

- V. Panniculectomy or abdominoplasty is considered **not medically necessary** for **any** of the following:
 - A. When there is no functional restoration needed meeting medically necessary criteria, the procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in [reconstructive surgery](#)
 - B. The treating surgeon has not provided sufficient documentation, including (when appropriate) quality color photographs or office records, which accurately depicts the extent of the clinical problem (see [Policy Guidelines](#) and [Documentation for Clinical Review](#) sections)
 - C. As an adjunct to other medically necessary procedures, including but not limited to, hysterectomy, and/or incisional or ventral hernia repair unless the above criteria are met
 - D. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes
 - E. The procedure is for [cosmetic](#) purposes only

Policy Guidelines

Based on the clinical judgment and the unique circumstances of each individual, Blue Shield of California Promise Health Plan reviewers have the discretion to approve any panniculectomy, regardless of the severity of the appearance of the panniculus or the severity of the complications, based on medical necessity.

Cosmetic surgery is distinguished from reconstructive surgery. Cosmetic surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

The technique of liposuction is considered **incidental** and included in the primary procedure. CPT code 15877 is used for liposuction; however, an unlisted CPT code may also be used.

There is no specific CPT code for repair of diastasis recti. A miscellaneous CPT code may be used.

For other procedures that may be requested at the same time as panniculectomy or abdominoplasty, such as brachioplasty, thighplasty, and circumferential body lift, consult the Blue Shield of California Promise Health Plan Medical Policy on Reconstructive Services.

Coding

See the [Codes table](#) for details.

Description

An abdominal panniculus is a redundant, large, and/or long overhanging apron of skin and subcutaneous fat located in the lower abdominal area. An abdominal panniculus is sometimes found on patients with obesity, or in patients who have experienced massive weight loss. Panniculectomy is a body contouring surgical procedure that removes excess skin and subcutaneous tissue (fat) from the lower to middle portions of the abdomen, typically after massive weight loss. It may be performed as a standalone procedure or combined with an abdominoplasty (also known as a "tummy tuck"). Abdominoplasty reconstructs and tightens the abdominal muscle and removes excess skin and fat, while a panniculectomy only removes excess skin and fat (panniculus).

Diastasis recti is a condition characterized by separation between the left and right side of the rectus abdominis however, does not represent a "true" hernia. Surgical procedures such as abdominoplasty may be used to repair diastasis recti.

These procedures can be performed endoscopically or by open procedure, alone or in combination, in either the outpatient or inpatient setting. They are most often performed for cosmetic reasons. The following addresses the medically necessary or reconstructive indications.

Related Policies

- Reconstructive Services

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers

are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

Regulatory Status

State:

The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do **either** of the following (see also Blue Shield of California Promise Health Plan Medical Policy: Reconstructive Services):

- Create a normal appearance to the extent possible
- Improve function

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Panniculectomy and Abdominoplasty

A panniculus is often described as a massive apron of fat and skin over the abdomen. The condition often occurs in morbidly obese individuals following substantial weight loss, due to significant overstretching of the lax anterior abdominal wall.

The severity of the panniculus is graded on a scale of 1 to 5, with 5 being the most severe:¹

- Grade 1: panniculus covers hairline and mons pubis but not the genitals
- Grade 2: panniculus covers genitals and upper thigh crease
- Grade 3: panniculus covers upper thigh
- Grade 4: panniculus covers mid-thigh
- Grade 5: panniculus covers knees and below

Surgical treatment of the redundant skin and fat is most often performed for cosmetic reasons to improve the appearance of the abdominal area. However, some individuals with a large abdominal panniculus may develop chronic skin irritation, intertrigo, infection, ulcers, and painful inflammation of the subcutaneous adipose tissue (i.e., panniculitis) in the abdominal folds from chronic skin-on-skin contact. When panniculitis is severe, it may interfere with activities of daily living, such as personal hygiene and ambulation. Medical treatment of these skin conditions, in addition to proper personal hygiene practices, generally involves topical or systemic corticosteroids, topical antifungals, and

topical or systemic antibiotics. Panniculectomy and wound closure may be required in chronic, severe cases where standard medical treatment has failed.

Panniculectomy is associated with substantial complication rates ranging from 12% to 51%, and major complications of hospitalization or surgical reintervention at rates of 10% to 15%.⁵ Complications include, but are not limited to, seroma, tissue necrosis, delayed healing, wound infection, hematoma, bleeding, and deep vein thrombosis.^{3,4} Complication rates were highest when panniculectomy was performed in conjunction with bariatric surgery or other procedures (i.e., hernia repair).⁵ Postbariatric body contouring (e.g., panniculectomy and abdominoplasty) is contraindicated in the following situations:⁶

- Unstable weight
- Non-compliance with lifestyle changes
- Unrealistic expectations of postoperative results such as contour irregularities, scarring, revisions, complications, prolonged recovery compression garments, and activity restrictions
- Smoking
- Malnutrition
- Unstable comorbidities
- Psychological instability

A weight loss of 100 plus pounds often leaves patients with a significant amount of loose hanging skin and tissue that can only be addressed with surgery.⁷ Panniculectomy is intended for patients with massive weight loss who are left with a large panniculus causing significant medical conditions that are unresponsive to medical treatment and negatively affecting quality of life.⁵ Massive weight loss is defined as a loss of 50% of excess weight.⁸ Panniculectomy, in contrast to abdominoplasty, does not include umbilicoplasty, undermining, and rectus muscle plication. The 2017 American Society of Plastic Surgeons (ASPS) Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients¹ indicated panniculectomy may be medically indicated if "panniculitis or chronic back pain have persisted despite an adequate trial of non-surgical management." Additionally, the individual should demonstrate weight stability for two to six months following a significant weight loss. For postbariatric surgery patients, this often occurs 12 to 18 months after surgery or at a basal metabolic index of 25 kilogram/milligram/squared (kg/mg^2) to 30 kg/mg^2 .^{1,6} If panniculectomy is performed prematurely, there is the potential for a secondary panniculus to develop once further weight loss has occurred. Further, studies have shown a reduction in postpanniculectomy complications in patients undergoing the procedure 18 months following bariatric surgery, compared with patients who underwent panniculectomy at the time of surgery.^{3,5,9} Additionally, Rubin⁶ stated "Before considering body contouring surgery the massive weight loss patient must be committed to maintaining lifestyle changes..." Colwell and Borud¹⁰, conducted a review of the literature on body contouring after massive weight loss and patient safety to provide a summary of current recommendations. The authors reported:

Literature consensus guidelines included completion and stabilization of weight loss before surgery with a body mass index ideally less than 32, smoking cessation, nutritional assessment, anemia screening, usage of mechanical prophylaxis against thromboembolism, and strong consideration for usage chemoprophylaxis with low molecular weight or unfractionated heparin.

The clinical significance of weight maintenance (stability) and weight loss is often questioned in studies that have provided marginal results. Two studies^{11,12} both operationally defined weight maintenance as a change of less than or equal to 5 pounds (2.3 kilograms [kg]). The 1998 Clinical Guidelines on the Evaluation and Treatment of Overweight and Obesity in Adults¹³ defined successful weight maintenance after weight loss as a weight regain of less than 3 kg (6.6 pounds) in two years and sustained reduction in waist circumference of at least 4 centimeters. The Institute of Medicine (2002)¹⁴ defined weight loss maintenance as losing at least 5% of body weight, or reducing body mass index by at least one unit, and keeping weight below this minimum amount for at least one

year. Stevens¹⁵ recommended a definition of weight maintenance as less than 3% change in body weight with greater than 5% change in body weight considered as clinically significant. These definitions are the product of observational studies, expert opinion, and review of the literature; however, randomized controlled trials have not been conducted. Thus, judgment of clinical significance requires further research and is under the interpretation of the reviewer.¹⁶

The ASPS Practice Parameter (2007) for Abdominoplasty and Panniculectomy Unrelated to Obesity or Massive Weight Loss² advised these procedures were most commonly performed for cosmetic indications such as “unacceptable appearance due to fat maldistribution or contour deformities caused by pregnancy, stretch marks, contracted scars and loose hanging skin after weight loss.” The Practice Parameter additionally advised, in rare circumstances should panniculectomy be performed for reconstructive indications unrelated to obesity or significant weight loss. When abdominoplasty or panniculectomy are performed to solely enhance an individual's appearance in the absence of functional abnormalities, the procedure is considered cosmetic in nature. However, panniculectomy is considered reconstructive when performed to correct or relieve structural defects of the abdominal wall, irregularities or pain caused by prior pelvic or lower abdominal surgery, intertriginous skin conditions and scarring. Further, rarely is hernia repair in conjunction with abdominoplasty or panniculectomy required.

Review of current evidence is insufficient to consider panniculectomy a medically beneficial procedure when medical necessity or reconstructive criteria are not met. This includes the concurrent use of panniculectomy as an adjunct to other medical necessary procedures, including but not limited to, hysterectomy, gastric bypass, and/or incisional or ventral hernia repair. The medical literature has made some suggestion that the presence of a large panniculus may interfere with a surgery or postoperative recovery, indicating panniculectomy would improve surgical site access, promote postoperative wound healing, or minimize wound complications.^{15,17,18}

Abdominoplasty is a surgical procedure intended to tighten lax anterior abdominal wall muscles and remove excess abdominal skin and/or fat. The standard procedure consists of excision of redundant tissue (panniculectomy), undermining of the superior flap, umbilicoplasty (preservation of the umbilicus on its stalk and repositioning of the umbilicus), rectus muscle plication, and wound closure. In order to improve the appearance of a protuberant abdomen, the abdominal wall is recontoured to create a firmer and flatter abdomen. Cosmetic “mini” or “modified” abdominoplasties that do not involve muscle tightening or creation of a new navel have also been performed on patients with minimal to moderate defects, mild to moderate skin laxity, and muscle flaccidity (ASPS, 2007).² There is sufficient literature, predominantly individual case reports^{19,20} that discuss the cosmetic benefits of abdominoplasty; however, there is little evidence to support a significant health benefit (e.g., improvements in physical function or back pain).²¹⁻²⁴ While panniculectomy can be performed in morbidly obese individuals, abdominoplasty in most cases should not. The act of lifting skin and fat off the underlying muscle in abdominoplasty places these patients at a very high risk of complications. For these patients it is best to lose the weight surgically or non-surgically before undergoing abdominoplasty.

There has been no correlation established between the presence of abdominal wall laxity or redundant panniculus and the development of neck or back pain. The majority of studies evaluating panniculectomy after weight loss are retrospective and methodologically weak.^{8,24-25} There are no studies providing data regarding the impact of panniculectomy or abdominoplasty on clinical outcomes other than complications. The evidence is insufficient to determine if panniculectomy effectively addressed medical conditions associated with a large panniculus such as back or groin pain.⁵

Diastasis Recti Repair

Diastasis recti, (also known as abdominal separation), is a disorder defined as a separation of the rectus abdominus muscle into right and left halves. Typically, the two sides of the muscle are joined

by the linea alba at the body midline. The condition of diastasis recti presents as a weakness or laxity of the anterior abdominal wall; as such, it does not constitute a "true" hernia. A "true" hernia is reducible, and surgical "repair involves opening fascia and/or dissection of a hernia sac with return of intraperitoneal contents back to the peritoneal cavity" (ASPS, 2017).² Diastasis recti is not considered a structural abnormality based on the high prevalence of the condition in the general population, particularly newborn and pregnant women. Surgical procedures such as abdominoplasty may be used to correct diastasis recti however there is no demonstrated functional health benefit (e.g., relieving back pain or improvement of physical function). There is insufficient literature to indicate the presence of diastasis recti, in the absence of hernia, resulted in any clinically significant functional impairment or complications that required surgical intervention.²⁶ Accordingly, the Reconstructive Surgery Act (1998)²⁷ does not apply to diastasis recti repair (see Blue Shield of California Promise Health Plan Medical Policy: Reconstructive Services). Therefore, surgical repair of diastasis recti alone or in combination with another abdominal procedure is considered not medically necessary.

Liposuction

The surgical procedure of liposuction, also known as lipoplasty or suction-assisted lipectomy, is the removal of excess fat with the goal of recontouring the body and improving appearance. Liposuction is usually carried out on the buttocks, hips, thighs and abdomen. It can be performed alone or in conjunction with panniculectomy or abdominoplasty. The technique of liposuction has not been shown in clinical trials to provide additional benefits beyond standard surgical techniques. When liposuction is performed alone and not as part of a medically necessary procedure, it is considered not medically necessary. When the technique of liposuction is performed in combination with a medically necessary panniculectomy, it is considered incidental to the primary procedure.

Summary of Evidence

Panniculectomy is indicated for panniculitis that is unresponsive to good personal hygiene and conservative management as defined in the medically necessary criteria. There is insufficient evidence supporting abdominoplasty for other than cosmetic purposes. However, panniculectomy and/or abdominoplasty may be covered as reconstructive surgery consistent with existing California law in accordance with the Reconstructive Surgery Act, as discussed in the guidelines above.

References

1. American Society of Plastic Surgeons (ASPS). Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. 2017. Accessed on September 16, 2025 from <https://www.plasticsurgery.org/documents/Health-Policy/Guidelines/guideline-2017-skin-redundancy.pdf>.
2. American Society of Plastic Surgeons (ASPS). Practice Parameter for Abdominoplasty and Panniculectomy Unrelated to Obesity or Massive Weight Loss. 2007. Archived. <https://www.plasticsurgery.org/for-medical-professionals/quality-and-registries/evidence-based-clinical-practice-guidelines>.
3. Arthurs ZM, Cuadrado D, Sohn V et al. Post-bariatric panniculectomy: pre-panniculectomy body mass index impacts the complication profile. *Am J Surg*. 2007; 193(5):567-570.
4. Leahy PJ, Shorten SM, Lawrence WT. Maximizing the aesthetic result in panniculectomy after massive weight loss. *Plast Reconstr Surg*. 2008; 122(4):1214-1224.
5. Hayes, Inc. Hayes Health Technology Brief. Panniculectomy for Abdominal Contouring Following Massive Weight Loss. Lansdale, PA: Hayes, Inc.; June, 2010. Archived 2015.
6. Rubin JP, Nguyen V, Schwentker A. Perioperative management of the post-gastric-bypass patient presenting for body contour surgery. *Clin Plast Surg*. 2004; 31(4):601-610.
7. Boswell CB. Body contouring following massive weight loss. *Mo Med*. 2010 May-Jun; 107(3):189-94.
8. Manahan MA, Shermak MA. Massive Panniculectomy after Massive Weight Loss. *Plastic & Reconstructive Surgery*. 2006 Jun; 117(7):2191-2197. doi:10.1097/01.prs.0000218174.89832.78.

9. Acarturk TO, Wachtman G, Heil B et al. Panniculectomy as an adjuvant to bariatric surgery. *Ann Plast Surg.* 2004; 53(4):360-366.
10. Colwell AS, Borud LJ. Optimization of patient safety in postbariatric body contouring: a current review. *Aesthet Surg J.* 2008 Jul-Aug; 28(4):437-42.
11. St Jeor ST, Brunner RL, Harrington ME et al. A classification system to evaluate weight maintainers, gainers, and losers. *J Am Diet Assoc.* 1997; 97:481-8.
12. Sherwood NE, Jeffery RW, French SA et al. Predictors of weight gain in the Pound of Prevention study. *Int J Obes Relat Metab Disord.* 2000; 24:395-403.
13. National Institute of Health. National Heart, Lung, and Blood Institute. Obesity Education Initiative. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight And Obesity in Adults. The Evidence Report. NIH Publication No. 98-4083. Sept 1998. Accessed on September 16, 2025 from http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf.
14. Institute of Medicine. Dietary Reference Intake for Energy, Carbohydrate, Fiber, Fat, Fatty Acids, Cholesterol, Protein and Amino Acids. Washington (DC): Washington National Academic Press; 2002.
15. Stevens WG, Vath SD, Stoker DA. "Extreme" cosmetic surgery: a retrospective study of morbidity in patients undergoing combined procedures. *Aesthet Surg J.* 2004 Jul-Aug; 24(4):314-8.
16. Donnelly JE, Blair SN, Jakicic JM et al. Appropriate Physical Activity Intervention Strategies for Weight Loss and Prevention of Weight Regain for Adults. *Medscape Nurses News.* Posted: 3/01/2010. Accessed on September 16, 2025 from <http://www.medscape.com/viewarticle/717049>.
17. Wright JD, Powell MA, Herzog TJ et al. Panniculectomy: Improving lymph node yield in morbidly obese patients with endometrial neoplasms. *Gynecol Oncol.* 2004; 94(2):436-441.
18. Olejek A, Manka G. Panniculectomy in gynecologic cancer surgical procedures by using a harmonic scalpel. *Acta Obstet Gynecol Scand.* 2005; 84(7):690-694.
19. Espinosa-de-los-Monteros A, de la Torre JI, Rosenberg LZ et al. Abdominoplasty with total abdominal liposuction for patients with massive weight loss. *Aesthetic Plast Surg.* 2006 Jan-Feb; 30(1):42-6.
20. Fracalvieri M, Datta G, Bogetti P et al. Abdominoplasty after weight loss in morbidly obese patients: a 4-year clinical experience. *Obes Surg.* 2007 Oct; 7(10):1319-24.
21. Toranto IR. Resolution of back pain with the wide abdominal rectus plication abdominoplasty. *Plast Reconstr Surg.* 1988 May; 81(5):777-9.
22. Ellabban MG, Hart NB. Body contouring by combined abdominoplasty and medial vertical thigh reduction: experience of 14 cases. *British Journal of Plastic Surgery.* 2004 Apr; 57(3):222-227. doi:10.1016/j.bjps.2003.12.011.
23. Coriddi MR, Koltz PF, Chen R et al. Changes in Quality of Life and Functional Status following Abdominal Contouring in the Massive Weight Loss Population. *Plastic and Reconstructive Surgery.* 2011 Aug; 128(2):520-526.
24. Nahas F. Discussion. Wide abdominal rectus plication abdominoplasty for the treatment of chronic intractable low back pain. *Plast Reconstr Surg.* 2011 Jan; 127(1):232-4.
25. Oneal, RM, Mulka JP, Shapiro P et al. Wide Abdominal Rectus Plication Abdominoplasty for the Treatment of Chronic Intractable Low Back Pain. *Plastic & Reconstructive Surgery.* 2011 Jan; 127(1):225-231. doi: 10.1097/PRS.0b013e3181fad2f7.
26. Jeyarajah R, Harford WV. Abdominal Hernias and Gastric Volvulus. In: Feldman: Sleisenger & Fordtran's Gastrointestinal and Liver Disease, 9th ed. Copyright© 2010 Saunders, an Imprint of Elsevier.
27. *Reconstructive Surgery Act (AB 1621).* 1998. Accessed on September 16, 2025 from http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1601-1650/ab_1621_bill_19980924_chaptered.html.
28. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 10000 thru 19999. Accessed April 21, 2026, from

https://mcweb.apps.prd.cammi.medi-cal.ca.gov/assets/351D1F95-1B91-42CE-8CF4-A527B40E0120/tarandnoncd1.pdf?access_token=6UyVkJRRfByXTZEWIh8j8QaYyIPyP5ULO

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Indication for procedure
 - For non-surgical weight loss, documentation of maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight)
 - Office progress notes indicating type and duration of medically supervised conservative treatments caused by panniculus for chronic and persistent skin conditions
 - Procedure reports or treatment records pertaining to treatment of skin condition or structural abnormality (if applicable)
 - Dated frontal and lateral preoperative medical quality color photographs accurately confirming panniculus and chronic skin condition or extent of the clinical problem (photos of skin condition may require separation or lifting of the panniculus)
 - Date of bariatric procedure (if applicable)
 - Documentation provided that if weight loss is the result of bariatric surgery, 12 months has passed after bariatric surgery and weight has been stable for at least 6 months
 - Documentation of a significant structural abnormality of the abdominal musculature caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease if the requested service is for abdominoplasty.

Post Service (in addition to the above, please include the following):

- Operative report(s)

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	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
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/01/2025	New policy.
05/01/2026	Administrative update. State Guidelines section updated.

Effective Date	Action
06/01/2026	Administrative update. Definitions of Decision Determinations section updated.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status

Below is an excerpt of the language taken from California Children's Services Numbered Letter 05-1020.*

*Department of Healthcare Services Numbered Letter 05-1020. Accessed April 21, 2026, from <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-05-1020-Experimental-and-Investigational-Services.pdf>

Policy

- A. The California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP) will not provide coverage for experimental services unless specifically authorized by law.
- B. The CCS Program and GHPP may provide coverage for an investigational service if:
 1. It is approved by the FDA under any Investigational New Drug (IND) Application; or
 2. It is authorized for use under the State of California's Right to Try Act; and
 3. Its use is consistent with its FDA-approved IND Application or the State of California's Right to Try Act;
- C. Additional criteria that will be considered in the adjudication process include:
 1. Conventional therapy will not adequately treat the intended patient's condition;
 2. Conventional therapy will not prevent progressive disability or premature death;
 3. The provider of the proposed service has a record of safety and success with it or equivalent to that of other providers of the investigational services;
 4. Other criteria (e.g., cost and availability) may be considered in the adjudication of a given request in cases in which more than one investigational service is available;
 5. There is reasonable expectation that the investigational service will significantly prolong the patient's life or will maintain or restore a range of physical and social function suited to activities of daily living; and
 6. The service is not being performed as part of a research study protocol. For a beneficiary with cancer who participates in a clinical trial for cancer, California Health and Safety Code (HSC) § 1370.6 requires that all routine patient care costs related to the clinical trial be covered if the beneficiary's CCS-paneled treating physician recommends participation

in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee. The coverage does not include investigational services that have not been approved by the FDA and that are associated with the clinical trial.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

Disclaimer: Blue Shield of California Promise Health Plan may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield of California Promise Health Plan reserves the right to review and update policies as appropriate.

Appendix A

State Guidelines/Policy Statement (No changes)	
BEFORE	AFTER
<p>Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti PHP_7.04</p> <p>State Guidelines: Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):</p> <ol style="list-style-type: none"> I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline: <ul style="list-style-type: none"> • N/A II. Department of Health Care Services (DHCS) Provider Manual Guideline: <ul style="list-style-type: none"> • TAR and Non-Standard Benefits List: Codes 10000 thru 19999 (tar and non cd1) <p style="margin-left: 40px;">The codes listed on the policy are included in the above Provider Manual; however, there are no specific clinical guidelines.</p> III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline: <ul style="list-style-type: none"> • N/A <p>Policy Statement: Any criteria that are not specifically addressed in the above Provider Manual, please refer to the criteria below.</p> <p>Panniculectomy Standard Criteria</p> <ol style="list-style-type: none"> I. Panniculectomy may be considered medically necessary when both of the following are met: <ol style="list-style-type: none"> A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease 	<p>Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti PHP_7.04</p> <p>State Guidelines: Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):</p> <ol style="list-style-type: none"> I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline: <ul style="list-style-type: none"> • N/A II. Department of Health Care Services (DHCS) Provider Manual Guideline: <ul style="list-style-type: none"> • TAR and Non-Standard Benefits List: Codes 10000 thru 19999 (tar and non cd1) <p style="margin-left: 40px;">The codes listed on the policy are included in the above Provider Manual; however, there are no specific clinical guidelines.</p> III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline: <ul style="list-style-type: none"> • N/A <p>Policy Statement: Any criteria that are not specifically addressed in the above Provider Manual, please refer to the criteria below.</p> <p>Panniculectomy Standard Criteria</p> <ol style="list-style-type: none"> I. Panniculectomy may be considered medically necessary when both of the following are met: <ol style="list-style-type: none"> A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease

State Guidelines/Policy Statement (No changes)	
BEFORE	AFTER
<p>B. Documentation to support either of the following:</p> <ol style="list-style-type: none"> 1. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) 2. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances <p>Panniculectomy After Weight Loss</p> <p>II. Panniculectomy, after weight loss, may be considered medically necessary when all of the following are met:</p> <ol style="list-style-type: none"> A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease B. Documentation to support either of the following: <ol style="list-style-type: none"> 1. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) 2. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure 	<p>B. Documentation to support either of the following:</p> <ol style="list-style-type: none"> 1. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) 2. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical procedure when needed for exposure due to extraordinary circumstances <p>Panniculectomy After Weight Loss</p> <p>II. Panniculectomy, after weight loss, may be considered medically necessary when all of the following are met:</p> <ol style="list-style-type: none"> A. There is documentation of a significant structural abnormality caused by a congenital defect, developmental abnormality, trauma, infection, tumors or disease B. Documentation to support either of the following: <ol style="list-style-type: none"> 1. For restoration of normal appearance when, for example, the panniculus hangs at or below the level of the symphysis pubis (documented by quality color clinical preoperative frontal and lateral photographs) 2. For restoration of normal function. For example, office notes document the panniculus is causing a chronic and persistent skin condition (e.g., panniculitis, cellulitis, non-healing skin ulceration, or intertriginous dermatitis) that remains refractory to at least three months of medically supervised conservative treatment (in addition to good hygiene practice; e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics); OR as an adjunct to a major surgical

State Guidelines/Policy Statement (No changes)	
BEFORE	AFTER
<p>when needed for exposure due to extraordinary circumstances</p> <p>C. Documentation of either of the following:</p> <ol style="list-style-type: none"> 1. For non-surgical weight loss, maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight) 2. If weight loss is the result of bariatric surgery, twelve months must pass after bariatric surgery before panniculectomy is performed and only when weight has been stable for at least six months <p>Abdominoplasty</p> <p>III. Abdominoplasty may be considered medically necessary when both of the following are met:</p> <ol style="list-style-type: none"> A. There is documentation of a significant structural abnormality of the abdominal musculature caused by a congenital defect, development abnormality, trauma, infection, tumors or disease B. The purpose of the procedure is to either: <ol style="list-style-type: none"> 1. Create a normal appearance to the extent possible 2. Improve function <p>Diastasis Recti Repair</p> <p>IV. Repair of diastasis recti (alone or in combination with another abdominal procedure) is considered not medically necessary for all indications.</p> <p>Other Indications for Panniculectomy or Abdominoplasty</p> <p>V. Panniculectomy or abdominoplasty is considered not medically necessary for any of the following:</p> <ol style="list-style-type: none"> A. When there is no functional restoration needed meeting medically necessary criteria, the procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in <u>reconstructive surgery</u> B. The treating surgeon has not provided sufficient documentation, including (when appropriate) quality color photographs or office records, which accurately depicts the 	<p>procedure when needed for exposure due to extraordinary circumstances</p> <p>C. Documentation of either of the following:</p> <ol style="list-style-type: none"> 1. For non-surgical weight loss, maintenance of a stable weight for at least six months (i.e., no significant weight loss or weight gain exceeding 5% of total body weight) 2. If weight loss is the result of bariatric surgery, twelve months must pass after bariatric surgery before panniculectomy is performed and only when weight has been stable for at least six months <p>Abdominoplasty</p> <p>III. Abdominoplasty may be considered medically necessary when both of the following are met:</p> <ol style="list-style-type: none"> A. There is documentation of a significant structural abnormality of the abdominal musculature caused by a congenital defect, development abnormality, trauma, infection, tumors or disease B. The purpose of the procedure is to either: <ol style="list-style-type: none"> 1. Create a normal appearance to the extent possible 2. Improve function <p>Diastasis Recti Repair</p> <p>IV. Repair of diastasis recti (alone or in combination with another abdominal procedure) is considered not medically necessary for all indications.</p> <p>Other Indications for Panniculectomy or Abdominoplasty</p> <p>V. Panniculectomy or abdominoplasty is considered not medically necessary for any of the following:</p> <ol style="list-style-type: none"> A. When there is no functional restoration needed meeting medically necessary criteria, the procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in <u>reconstructive surgery</u> B. The treating surgeon has not provided sufficient documentation, including (when appropriate) quality color

State Guidelines/Policy Statement (No changes)	
BEFORE	AFTER
<p>extent of the clinical problem (see <u>Policy Guidelines</u> and <u>Documentation for Clinical Review</u> sections)</p> <p>C. As an adjunct to other medically necessary procedures, including but not limited to, hysterectomy, and/or incisional or ventral hernia repair unless the above criteria are met</p> <p>D. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes</p> <p>E. The procedure is for <u>cosmetic</u> purposes only</p>	<p>photographs or office records, which accurately depicts the extent of the clinical problem (see <u>Policy Guidelines</u> and <u>Documentation for Clinical Review</u> sections)</p> <p>C. As an adjunct to other medically necessary procedures, including but not limited to, hysterectomy, and/or incisional or ventral hernia repair unless the above criteria are met</p> <p>D. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes</p> <p>E. The procedure is for <u>cosmetic</u> purposes only</p>