Medicare Medical Policy

Liposuction for Lipedema

MEDICARE MEDICAL POLICY NUMBER: 351

Effective Date: 9/1/2024

Last Review Date: 8/2024

Next Annual Review: 8/2025

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
Liposuction *(Suction Assisted Lipectomy) (15877-15879)*	Local Coverage Determination (LCD) for *Plastic Surgery* (L37020) **NOTE:** This LCD states, "…when the procedure is utilized to remove a lipoma, it is considered reconstructive surgery. The clinical record must clearly demonstrate medical necessity for the lipoma removal as most such tumors are benign and do not require removal. All other uses are currently considered cosmetic in nature and non-covered." Therefore, suction assisted lipectomy is considered cosmetic for any condition other than lipomas.

Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below*)

- **Medicare Coverage Manuals:** Medicare does not have criteria for liposuction, for any indication, in a coverage manual. **However, broad exclusionary statements are provided by Medicare for potentially cosmetic procedures in general.**[1,2] This coverage guidance is considered "not fully established" under CFR § 422.101(6)(i)(A) as additional criteria are needed to interpret or supplement these general coverage provisions in order to determine medical necessity consistently.
- **National Coverage Determination (NCD):** Medicare does not have criteria for liposuction in an NCD for any indication.
- **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** With the exception of the liposuction services addressed by an LCD above, as of the most recent policy review, no Medicare Administrative Contractors (MACs) have LCDs for liposuction used to treat lipedema. The billing and coding companion LCA (A57222) includes the CPT codes in question, but coverage detailed in the LCD is limited to **abdominal** lipectomy/panniculectomy, which means liposuction of non-abdominal regions is not within the scope of this LCD.

- Therefore, in the absence of established Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the service area in which the testing is being performed, Company criteria below are applied for medical necessity decision-making. Medicare statutes and regulation provide general coverage criteria for potentially cosmetic, but additional criteria to interpret or supplement the Medicare criteria are being used in order to determine medical necessity consistently. These additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services **because the use of this additional criteria based on peer-reviewed evidence evaluates safety and efficacy of liposuction for lipedema**. Specifically, the literature review is used to evaluate whether or not these procedures show long-term improvement in mobility, pain, and quality of life with minimal post-operative adverse effects. Liposuction may be considered medically necessary when the individual meets the stated criteria, including conservative treatment.
- ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*

Excision (with or without Lipectomy) (15832-15836)	Company medical policy for Liposuction for Lipedema I. This service may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. This service is considered **not medically necessary** for Medicare when the Company medical policy criteria are not met. *See Policy Guidelines below.*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

- Bariatric Surgery, MP37
- Cosmetic and Reconstructive Procedures, MP232

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
    - History
    - Physical examination
    - Treatment plan.

LIPECTOMY AND LIPOSUCTION

Lipectomy is the surgical removal of adipose or fat tissue. A lipectomy can be performed in order to excise a lipoma (a fatty tumor), but it can also be performed to remove excess fatty tissue to reshape the contours of the face, neck, trunk, and extremities as a component of cosmetic surgery.

Liposuction (suction-assisted lipectomy) is the aspiration of subcutaneous fat via a suction method. A suction cannula is inserted through a small incision into the fatty areas and a vacuum is applied, allowing the fat to be drawn out of the body into collection containers. Liposuction is also frequently a component of cosmetic surgery.

MEDICARE AND MEDICAL NECESSITY

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development.

Since there are not fully established coverage criteria for liposuction procedures to treat lipedema available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy

criteria will be applied. See the Medicare Coverage Criteria table above for more information regarding the use of internal coverage criteria when Medicare coverage criteria are not fully established.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

See associated local coverage articles (LCAs) for related billing and coding guidance:

- LCA: Billing and Coding: Plastic Surgery (A57222)

CODES*		
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
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity
HCPCS	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and

Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §120 - Cosmetic Surgery. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c16.pdf. Accessed 7/22/2024.
2. Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10). https://www.ssa.gov/OP_Home/ssact/title18/1862.htm. Accessed 7/22/2024.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
9/2022	New Medicare Advantage medical policy (converted to new format 2/2023)
9/2023	Annual review; no changes
9/2024	Annual review; no changes