MEDICAL POLICY

Medical Policy Title	**Abdominoplasty, Panniculectomy, and Lipedema Reduction Surgery**
Policy Number	**7.01.53**
Current Effective Date	May 22, 2025
Next Review Date	May 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

Abdominoplasty

I. An abdominoplasty ("tummy tuck") or belt lipectomy ("lower body lift") is considered a cosmetic procedure and, therefore, is **not medically necessary** for all indications.

Panniculectomy

II. A panniculectomy is considered **medically appropriate** when medical records document **ALL** of the following criteria:

   A. The panniculus is Grade 2 (panniculus covers genitals and upper thigh crease) or higher, documented by photographs;

   B. A significant functional impairment of a recurrent or persistent medical condition directly related to the excess tissue and skin folds of the panniculus (e.g., intertrigo, dermatitis, cellulitis, panniculitis, ulceration, or necrosis) which is:

      1. Documented by color photographs;

      2. Refractory to at least three (3) months of prescribed standard medical management including **BOTH** of the following:

         a. adherence to prescribed hygiene practices and/or applicable wound care; **and**

         b. adherence to prescribed systemic antibiotics, antifungal agents, or corticosteroids;

   C. There is a documented expectation that surgery will improve or resolve the significant functional impairment;

   D. If the member had a significant weight loss, detailed medical records document **EITHER** of the following:

      1. If the weight loss is secondary to bariatric surgery, **ALL** of the following must be met:

         a. A minimum of 18 months has elapsed from the date of the bariatric surgery;

         b. Stable weight was maintained for at least six (6) months prior to the consultation for panniculectomy, **and**

         c. Significant post-operative weight loss is documented by of **ONE (1)** of the

following:

i. Body Mass Index (BMI) has reached less than or equal to 30 kg/m^2;

ii. Documentation of at least a 100-pound weight loss; or

iii. The achieved weight loss is 40% or greater of the excess body weight that was present prior to the individual's weight loss program or surgical intervention; **or**

2. If the weight loss was unrelated to bariatric surgery, **BOTH** of the following must be met:

a. BMI is less than or equal to 30 kg/m^2 range, **and**

b. Stable weight was maintained for at least six (6) months prior to the consultation for panniculectomy.

III. A panniculectomy is considered **not medically necessary** for any other sole indication, including by not limited to:

A. Improvement of a member's appearance or self-esteem;

B. Correction of poorly fitting clothes, or problems with hygiene;

C. Treatment of superficial inflammation or infection when controlled only with topical medications;

D. For the correction of neck or back pain;

E. When performed as an adjunct to other medically necessary abdominal or gynecological surgery (e.g., ventral hernia repair, bariatric surgery, hysterectomy, pelvic procedure), **unless** that criteria are met separately.

<u>Lipedema Reduction Surgery</u>

IV. Lipectomy or liposuction for the treatment of lipedema is considered **medically appropriate** when **ALL** of the following criteria are met:

A. The patient has documented clinical exam findings that support the diagnosis of lipedema, including but are not limited to palpable nodules in the adipose tissue, bilateral symmetric adiposity in the extremities, non-pitting edema, easy bruising, pain or tenderness to palpation at affected areas, negative Stemmer sign;

B. The patient has not responded to at least six (6) consecutive months of optimal conservative medical management (e.g., weight loss, exercise compression garment/device, and manual lymph drainage);

C. The patient has **ONE (1)** of the following:

1. a significant physical functional deficit (e.g., difficulty ambulating or performing activities of daily living); **or**

2. a documented medical complication (e.g., recurrent cellulitis);

D. The patient's plan of care is to wear compression garments as instructed and continue conservative treatment, post-operatively, to maintain benefits, including weight management.

V. Lipectomy or liposuction is considered cosmetic and **not medically necessary** when performed for the sole purpose of removal of fat without a documented functional deficit. However, lipectomy may be an integral part of other covered services.

RELATED POLICIES

Corporate Medical Policy

7.01.11 Cosmetic and Reconstructive Procedures

POLICY GUIDELINE(S)

I. Preoperative photographs are an absolute requirement for determination of medical appropriateness.

II. Documentation of functional deficit(s), all prescribed standard medical management, and weight trends can be documented by any of the member's treating providers, including but not limited to the performing surgeon, primary care physician and/or specialist (e.g., wound care, dermatology).

III. The criteria for panniculectomy apply regardless of the cause of the excess fatty tissue and/or redundant skin. These criteria apply to removal of fatty tissue and/or redundant (excessive) skin caused by obesity and apply to weight loss due to any reason, including bariatric surgery.

IV. A panniculectomy is ideally performed after the patient maintains a stable weight for two (2) to six (6) months. For post bariatric surgery patients, this often occurs 12-18 months after surgery or at the 25 kg/mg^2 to 30 kg/mg^2 weight range (ASPS 2017).

V. The American Society of Plastic Surgeons' (2017) grading system for the severity of abdominal deformities is as follows:

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

DESCRIPTION

The American Society of Plastic Surgeons (2017) defines the following:

Abdominoplasty ("tummy tuck") is typically performed for cosmetic purposes, involves the removal of excess skin and fat from the pubis to the umbilicus or above, and may include fascial plication of the rectus muscle diastasis and a neoumbilicoplasty.

Circumferential lipectomy (also known as belt lipectomy or lower body lift) is a circumferential procedure which combines the elements of an abdominoplasty or panniculectomy with removal of excess skin/fat from the lateral thighs and buttock. The procedure involves removing a "belt" of tissue from around the circumference of the lower trunk which eliminates lower back rolls, and provides some elevation of the outer thighs, buttocks, and mons pubis. A circumferential lipectomy describes an abdominoplasty or panniculectomy combined with flank and back lifts, both procedures being performed together sequentially and including suction assisted lipectomy, where necessary.

Panniculectomy involves the removal of hanging excess skin/fat in a transverse or vertical wedge but does not include muscleplication, neoumbilicoplasty or flap elevation. Deformities associated with massive weight loss vary greatly depending on the patients' body type, their fat deposition pattern, and the amount of weight gained or lost. These deformities can lead to patient dissatisfaction with appearance, inability to exercise, impaired ambulation, chronic back, neck and shoulder pain, difficulty with hygiene and symptoms such as uncontrolled intertrigo, infections, and skin necrosis.

A panniculectomy could be considered as a functional correction in patients who are of appropriate height and weight, and have a history of problems including panniculitis or chronic back pain that have persisted despite an adequate trial of non-surgical management, or have a functional impairment in activities of daily living/work, etc. Body contouring surgery is ideally performed after the patient maintains a stable weight for two (2) to six (6) months. For post-bariatric surgery patients, this often occurs 12 to 18 months after surgery or at the 25 kg/mg^2 to 30 kg/mg^2 weight range (ASPS 2017).

<u>Lipedema</u>

Lipedema is a disease of fibrotic loose connective (adipose) tissue (LCT) on the lower abdomen, hips, buttocks, and limbs of females, typically sparing the trunk, hands, and feet (Herbst 2021). Lipedema tissue is difficult to reduce by diet, exercise, or bariatric surgery. Symptoms include heaviness, pain (particularly with pressure), loss of strength, and easy bruising. The presence of nodular and/or fibrotic texture is palpable in affected areas, with nodules that may feel like rice or peas, and can create an uneven dimpled appearance.

Lipedema typically spares the hands/feet and presents with a negative Stemmer sign. However, a positive Stemmer sign does not rule out lipedema, and likely indicates the presence of concomitant lymphedema. If both conditions are present, this is termed "Lipo-Lymphedema." To perform the Stemmer test the examiner pinches the dorsal skin proximal to the metatarsophalangeal (MTP) joint of the second toe (or metacarpophalangeal joint of the second finger). If the examiner cannot create a fold of pinched skin, this results in a positive sign.

Skin and lipedema LCT are graded by stage and location. The excessive fat deposits are typically unresponsive to traditional weight loss interventions and there is no cure. Untreated lipedema may result in secondary problems including osteoarthritis and reduced mobility. Over time, the weight of the excessive fat build-up can impair the ability to walk. Initially, the lymphatic system can cope with the increased amount of interstitial fluid, but in the later stages, secondary lymphedema (lipolymphoedema) can occur if the fatty deposits compromise the lymphatic system.

The goal of therapy is to reduce symptoms, disability, and functional limitations, and prevent disease

progression. Conservative treatment includes manual lymphatic drainage, compression stockings, intermittent pneumatic compression, skin care, and exercise. Individuals with lipedema may have obesity as a comorbidity, and diet is frequently prescribed. Conservative care may alleviate symptoms, but treatments are short-lived and may require repeat treatment within days. For individuals who do not respond to conservative treatment, liposuction may be recommended.

SUPPORTIVE LITERATURE

Badran and colleagues (2023) conducted a meta-analysis aimed to establish whether surgical fat removal, similar to bariatric surgery, exerts measurable, lasting metabolic benefits. From the 22 studies (n=496 participants) included in the review, the authors concluded that surgical fat removal exerts several metabolic benefits in the short term, but only improvements in insulin sensitivity last beyond 6 months. Transient benefits were observed in body mass index (BMI), blood pressure, serum leptin, and tumor necrosis factor-alpha (TNF-α). Reported findings include that insulin sensitivity improved gradually with a maximum reduction in fasting insulin and homeostatic model assessment for insulin resistance. Peak metabolic benefits manifest as a reduction of 2 units in body mass index, 3 kilograms of fat mass, 5 centimeters of waist circumference, 15 μg/L of serum leptin, 0.75 pg/ml of tumor necrosis factor-alpha, 0.25 mmol/L of total cholesterol, and 3.5 mmHg of systolic and diastolic blood pressure that were observed at day 50 but were followed by a return to preoperative levels by day 180. Serum high-density lipoproteins peaked at 50 days post-surgery before falling below the baseline. No significant changes were observed in lean body mass, serum adiponectin, resistin, interleukin-6, C-reactive protein, triglyceride, low-density lipoproteins, free fatty acids, and fasting blood glucose.

Liposuction for Lipedema

Dadras and colleagues (2017) examined the long-term results of liposuction in patients with lipedema from July 2010 to July 2013. A total of 25 patients were included in the study, and all patients were available for follow-up in 2015. All patients had lipedema of the lower limb. Additional upper limb involvement was present in 9 patients (36%). One patient had stage I lipedema, 11 patients had stage II lipedema, and 13 patients had stage III lipedema. On average, patients received 3 procedures, with a range of 1 to 7 procedures. A total of 72 liposuctions were performed on the 25 patients. In 41 liposuctions, a vibration-assisted device was used, and in 31 liposuctions, a water jet-assisted device was used. Patients showed significant reductions in spontaneous pain, sensitivity to pressure, feeling of tension, bruising, cosmetic impairment, and general impairment to quality of life from the preoperative period to the first postoperative follow-up, and these results remained consistent until the second postoperative follow-up. A comparison of the preoperative period to the last postoperative follow-up, after 4 patients without full preoperative combined decongestive therapy (CDT) were excluded from the analysis, indicated that the need for CDT was reduced significantly. An analysis of the different stages of the disease also indicated that better and more sustainable results could be achieved if patients were treated in earlier stages. The authors concluded that liposuction is effective in the treatment of lipedema and leads to an improvement in quality of life and a decrease in the need for conservative therapy.

In 2019, the Canadian Agency for Drugs and Technologies in Health conducted a qualitative

systematic review of liposuction for the treatment of lipedema (Peprah 2019). The authors identified one clinical guideline and five uncontrolled before-and-after studies that suggested that liposuction may be effective in reducing the size of the extremities, symptoms, and functional limitations of lipedema. One of the publications was a follow-up to an earlier study. All studies were conducted in Germany and the guideline were intended for clinical practice in the Netherlands; therefore, the generalizability of the findings is unclear. Limitations of the evidence included the lack of controlled trials and patient's self-assessment with scales that had not been validated for use in patients with lipedema.

Mortada and colleagues (2024) performed a systematic review and meta-analysis to assess the efficacy and safety of liposuction for individuals with lipedema. The review included 20 studies (N=1785 patients) published up to March 2023. The selected studies comprised 14 prospective cohort studies, 3 retrospective studies, 2 case series, and 1 cross-sectional study. Based on data from 14 studies, the majority of patients were classified as stage 2 (503 individuals), followed by stage 3 (467 individuals), and a smaller number at stage 1 (64 individuals). There were no cases classified as advanced (Stage IV) disease. Lipedema was most frequently observed in the outer and inner legs, as well as the arms. The most commonly utilized technique was tumescent liposuction (81%), followed by power-assisted liposuction (35%) and water-assisted liposuction (WAL) (29%). The data analysis showed an average of 2.88 (± 1.30) treatment sessions per patient, with a mean aspirate volume of 4,429 mL per session. Liposuction sessions varied from 1 to 2.5 hours, and 11 (of 20) studies reported postoperative use of compression garments. A meta-analysis of nine studies revealed improvements in the quality of life ($p<.0001$), pain ($p<.0001$), pressure sensitivity ($p<.0001$), bruising ($p<.0001$), cosmetic impairment ($p<.0001$), heaviness ($p<.0001$), walking difficulty ($p<.00001$), and itching among lipedema patients who underwent liposuction. Although complications such as inflammation, thrombosis, seroma, hematoma, and lymphedema-related skin changes were reported, severe complications were rare. No instances of shock, recurrence, or mortality were reported. The mean follow-up duration for the patients across studies was 15 months, (range, 1 to 96 months). The systematic review was based on prospective cohort studies, which introduces a risk of publication bias. Insufficient detail in some reports contributed to potential data inconsistencies. Moreover, 70% (14 of 20) of the studies originated from Germany, highlighting the possibility of important differences in the approach to clinical care that may limit generalizability. The authors conclude that liposuction, especially the tumescent technique, is effective in treating lipedema, enhancing outcomes across different modalities. However, the literature lacks data on liposuction's impact on secondary lymphedema.

A meta-analysis by Fijany and colleagues (2024) aimed to evaluate the efficacy and safety of different liposuction techniques in patients with lipedema, incorporating 10 studies with post-operative outcomes and complication data. The studies comprised of two using traditional tumescent liposuction (TTL), five utilizing power-assisted liposuction (PAL), one employing WAL, and two studies featuring both PAL and WAL. In total, 2,542 procedures performed on 906 patients were analyzed. Consistent with the findings of Mortada and colleagues (2024), the combined outcomes for all techniques showed significant improvements in pain relief, reduction of bruising and edema, decreased tension, reduced pressure sensitivity, and enhanced cosmetic and general impairment (all $p<0.00001$). TTL, PAL, and WAL each significantly contributed to reducing pain, bruising, swelling,

pressure sensitivity, and cosmetic impairment (all $p<0.05$). WAL was particularly effective in alleviating tension and general impairment (all $p<0.005$); however, the heterogeneity for these outcomes was high. The overall complication rates reported were low, with TTL at 1.5%, PAL at 4.0%, WAL at 0%, and studies using both PAL and WAL at 2.3%.

PROFESSIONAL GUIDELINE(S)

Abdominoplasty

In 2018, the American Society of Plastic Surgeons (ASPS) reaffirmed the recommended insurance coverage criteria for third-party payers related to abdominoplasty. According to the ASPS, as surgical techniques have progressed over the years, abdominoplasty has been utilized to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. When an abdominoplasty is performed solely to enhance a patient's appearance in the absence of any signs or symptoms of functional abnormalities, the procedure should be considered cosmetic in nature and not a compensable procedure.

Panniculectomy

In 2019, the ASPS re-approved the recommended insurance coverage criteria for third-party payers related to panniculectomy. Indicating that panniculectomy should be considered a reconstructive procedure when performed to correct or relieve structural defects of the abdominal wall, improve skin health within the fold beneath the pannus, and/or help improve chronic low back pain due to functional incompetence of the anterior abdominal wall.

In 2017, the ASPS issued a practice parameter for surgical treatment of skin redundancy for obese and massive weight loss patients. The ASPS outlines preoperative assessment and screening, management (e.g., timing, operative treatment), and postoperative care.

Liposuction for Lipedema

A 2017 international consensus conference on lipedema identified studies from Germany that reported long-term benefits for up to 8 years following liposuction, concluding that lymph-sparing liposuction is the only effective treatment for lipedema (Sandhofer 2017).

In 2021, a consensus document sponsored by the American Association of Plastic Surgeons evaluated the evidence on surgical treatment of lymphedema (Chang 2021). The conference recommended, based on grade 1C (very low quality) evidence, that there is a role for debulking procedures such as liposuction and for liposuction combined with physiologic procedures in reducing the nonfluid component in lymphedema.

In 2021, a consensus on the standard of care for lipedema in the United States was created by a panel of 21 lipedema experts (Herbst 2021). According to the panel, lipedema reduction surgery is currently the only available technique for removing abnormal lipedema tissue (e.g., adipocytes, nodules, fibrotic extracellular matrix, and other non-adipocyte components). It is also the only treatment that slows progression of lipedema and ideally would be performed before complications and disabilities from lipedema develop. The panel found that lipedema reduction surgery significantly improves symptoms, mobility, stance, gait, valgus rotation/deformity of the knee and ankle, quality of

life, and redistributes and restores the plantar arch. It also improves lymphatic symptoms, reducing the need for compression and manual therapy and improves lymphatic function as shown by radionucleotide lymphangioscintigraphy.

- Grade A consensus recommendations include that lipedema should be regarded as a LCT disease versus a disease of just adipocytes (fat); lipedema has a distinct distribution of pathologic tissue that differs from non-lipedema obesity.
- Grade B consensus recommendations include that lipedema LCT can affect the abdomen; lipedema tissue is resistant to reduction by diet, exercise, or bariatric surgery; rice-grain, pearl-sized or larger nodules in LCT should be part of the diagnostic criteria for lipedema; lipedema tissue is frequently painful especially when touched.
- Grade C consensus recommendations include that standard conservative therapy for lipedema includes nutritional guidance, manual therapy, compression garments, pneumatic compression device (external pump), and a home exercise.

In 2022, the National Institute for Health and Care Excellence (NICE 2022) issued clinical guidance addressing the use of liposuction in lipedema. They recommend liposuction for lipedema should be used only in the context of research because the evidence on the safety and efficacy is inadequate.

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	; thigh
15833	; leg
15834	; hip
15835	; buttocks

Code	Description
15836	; arm
15837	; forearm or hand
15838	; submental fat pad
15839	; other area
15847 (NMN)	; abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)
15876	Suction assisted lipectomy; head and neck
15877 (*NMN)	; trunk *NMN when used for abdominoplasty or belt lipectomy
15878	; upper extremity
15879	; lower extremity

HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

American Society of Plastic Surgeons [Internet]. ASPS recommended insurance coverage criteria for third-party payers. Abdominoplasty. 2006 Jul; Reaffirmed 2018 Sept 26. [accessed 2025 Mar 25]. Available from: https://www.plasticsurgery.org/documents/Health-Policy/Reimbursement/insurance-2018-abdominoplasty.pdf

American Society of Plastic Surgeons [Internet]. ASPS recommended insurance coverage criteria for third-party payers. Panniculectomy. 2006 Jul; Re-approved 2019 Mar [accessed 2025 Apr 14]. Available from: https://www.plasticsurgery.org/documents/Health-Policy/Reimbursement/insurance-2019-panniculectomy.pdf

American Society of Plastic Surgeons [Internet]. Practice parameter for surgical treatment of skin redundancy for obese and massive weight loss patients. 2017 June [accessed 2025 Apr 14]. Available from: https://www.plasticsurgery.org/documents/Health-Policy/Guidelines/guideline-2017-skin-redundancy.pdf

Badran S, et al. Metabolic changes after surgical fat removal: A dose-response meta-analysis. J Plast Reconstr Aesthet Surg. 2023 Jan;76:238-250. Epub 2022 Nov 2.

Baumgartner A, et al. Long-term benefit of liposuction in patients with lipoedema: a follow-up study after an average of 4 and 8 years. Br J Dermatol. 2016 May;174(5):1061-7.

Brodell RT, et al. Intertrigo [Internet]. In: UpToDate, Fowler J, Ofori AO (Eds), Wolters Kluwer. Last updated 2025 Jan [accessed 2025 Apr 14]. Available from: https://www.uptodate.com/contents/intertrigo

Chang DW, et al. Surgical treatment of lymphedema: a systematic review and meta-analysis of controlled trials. results of a consensus conference. Plast Reconstr Surg. 2021 Apr 01;147(4):975-993.

Dadras M, et al. Liposuction in the treatment of lipedema: a longitudinal study. Arch Plast Surg. 2017 Jul;44(4):324-331.

Fijany AJ, et al. Comparing the safety and effectiveness of different liposuction techniques for lipedema. J Plast Reconstr Aesthet Surg. 2024 Oct;97:256-267.

Gomez-Samano MA, et al. Effect of liposuction on body weight and serum concentrations of leptin, lipids, glucose, and insulin: a meta-analysis. Plast Reconstr Surg. 2023 Mar 1;151(3):402e-411e.

Herbst KL, et al. Standard of care for lipedema in the United States. Phlebology. 2021 Dec;36(10):779-796.

Mortada H, et al. Safety and effectiveness of liposuction modalities in managing lipedema: systematic review and meta-analysis. Arch Plast Surg. 2024 Aug 6;51(5):510-526.

National Institute for Health and Care Excellence (NICE) [Internet]. Liposuction for chronic lipoedema. Interventional procedures guidance. IPG721. 2022 May [accessed 2025 Apr 14]. Available from: https://www.nice.org.uk/guidance/ipg721

Peprah K, MacDougall D. Liposuction for the treatment of lipedema: a review of clinical effectiveness and guidelines [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2019 Jun 7 [accessed 2025 Apr 14]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK545818/

Sachs D, et al. Panniculectomy. StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; last updated: 2023 Jul [accessed 2025 Mar 25]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK499822/

Sandhofer M, et al. Prevention of progression of lipedema with liposuction using tumescent local anesthesia: results of an International Consensus Conference. Dermatol Surg. 2020 Feb;46(2):220-228.

Shestak KC, et al. Evidenced-based approach to abdominoplasty update. Aesthet Surg J 2019 May 16;39(6):628-642.

Troppmann C, et al. Impact of panniculectomy on transplant candidacy of obese patients with chronic kidney disease declined for kidney transplantation because of a high-risk abdominal panniculus: A pilot study. Surgery. 2016 Jun;159(6):1612-1622.

Witte T, et al. Water-jet-assisted liposuction for the treatment of lipedema: standardized treatment protocol and results of 63 patients. J Plast Reconstr Aesthet Surg. 2020 Mar 14;S1748-6815(20)30119-4.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Based upon our review, abdominoplasty and panniculectomy are not addressed in National or Regional Medicare coverage determinations or policies.

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

05/28/02, 03/27/03, 04/22/04, 05/27/04, 08/04/04, 08/25/05, 06/22/06, 04/26/07, 04/24/08, 04/23/09, 04/29/10, 04/28/11, 04/26/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 06/22/17, 04/26/18, 04/25/19, 04/23/20, 04/22/21, 04/21/22, 04/20/23, 06/20/24, 05/22/25

Date	Summary of Changes
05/22/25	• Annual update, title updated to reflect that lipedema reduction surgery criteria was merged from the Cosmetic and Reconstructive Surgery CMP 7.01.11.

01/01/25	• Summary of changes tracking implemented.
03/28/02	• Original effective date