Medical Coverage Policy

Effective Date..... 6/15/2021
Next Review Date..... 6/15/2022
Coverage Policy Number 0470

Redundant Skin Surgery

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INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses surgical procedures for excision of redundant or excessive skin.

Coverage Policy

Coverage for redundant skin surgery varies across plans. Refer to the customer's benefit plan document for coverage details.

If coverage for the specific service is available, the following conditions of coverage apply.

Rhytidectomy or procedures for excision of redundant or excessive skin of other anatomical areas* (e.g., neck, upper and lower extremities, buttocks) is considered medically necessary when ALL of the following criteria are met:

- There is presence of a functional deficit due to a severe physical deformity or disfigurement resulting from the redundant or excessive skin.
- The surgery is expected to restore or improve the functional deficit.

- The redundant or excessive skin is demonstrated on preoperative photographs.
- The redundant or excessive skin is interfering with activities of daily living.
- For areas other than the face, there is evidence, including photographs, that the redundant or excessive skin is causing persistent intertriginous dermatitis, cellulitis, or skin ulceration, which is refractory to at least three (3) months of medical management, including all applicable treatments. In addition to good hygiene practices, applicable treatment should include topical antifungals; topical and/or systemic corticosteroids; and/or local or systemic antibiotics.

Rhytidectomy, or procedures for excision of redundant or excessive skin of other anatomical areas* (e.g., upper and lower extremities, buttocks) for ANY of the following are considered cosmetic in nature and not medically necessary:

- The surgery is being performed to treat psychological symptomatology or psychosocial complaints, in the absence of significant physical, objective signs.
- The surgery is being performed for the primary purpose of improving appearance.
- The suction-assisted lipectomy is performed alone and not as part of another medically necessary procedure.
- The surgery is for rhytidectomy for glabellar frown lines.

***Please refer to Cigna Medical Coverage Policies for Panniculectomy and Abdominoplasty, and Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift for criteria relating to these surgical procedures. This policy is intended to address redundant skin surgery for anatomical areas not addressed in those Coverage Policies.**

Labiaplasty is considered cosmetic in nature and not medically necessary. Please refer to the Cigna Coverage Policy for Treatment of Gender Dysphoria for information regarding labiaplasty procedure as part of initial gender reassignment surgery.

Note: If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six months. If the weight loss is the result of bariatric surgery, surgery for excision of redundant skin should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months.

General Background

A rhytidectomy is the surgical excision of wrinkles. It may include removing excess skin, tightening of muscles and redraping of the skin. When the procedure is performed on the facial area, it is also referred to as a facelift. A cervicofacial rhytidectomy involves neck and face components. When it is performed on the forehead area, it may be referred to as a forehead lift or brow lift. (For information regarding redundant skin surgery from the brow area, refer to the CIGNA Medical Coverage Policy: Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift.) Initially, facelifts consisted mainly of subcutaneous undermining. With increased knowledge of anatomy, the procedure developed and may involve the underlying structures, including the superficial musculoaponeurotic system (SMAS) and platysma muscle The SMAS is a fascial layer that underlies the skin in the parotid and cheek areas. The platysma is a large muscle that is located in the subcutaneous plane of the neck, extending from the lower cheek and mandible to the upper chest (Friedman, 2006). It is thought that advancement of the SMAS and platysma muscle will result in an enhanced outcome compared to excisions of skin alone. These procedures are usually performed on an outpatient basis. A cervicoplasty is removal of excess skin from the neck area.

Rhytidectomy procedures and other procedures, including cervicoplasty, that involve the excision of redundant skin and fat are usually performed solely for cosmesis, with the primary purpose being to improve appearance. The most common reason for performing a rhytidectomy procedure is to reverse the signs of aging. There are rare situations where these procedures may be performed to correct a functional impairment and would be considered medically necessary. In the facial area, a functional impairment may be due to facial paralysis or

palsy. The functional impairment may involve difficulty with eating, swallowing and achieving oral continence (e.g., an inability to take in food or liquids orally).

Rhytidectomy procedures for glabellar frown lines, or the area that is above the nose and between the eyebrows, is considered to be cosmetic in nature. The primary purpose of this procedure is to remove wrinkles, with no functional deficit being corrected.

Removal of excessive or redundant skin may be performed in other areas of the body, including the thigh, leg, hip, buttock, abdomen and arm areas. (For information on redundant skin removal from the abdominal area, refer to the CIGNA Medical Coverage Policy: Panniculectomy and Abdominoplasty) Depending on the body area, these procedures may be referred to as buttock lift, thigh lift, leg lift, or arm lift (i.e., brachioplasty). These procedures may also involve the removal of subcutaneous tissue, including lipectomy (i.e., removal of fat deposits). Lipectomy may be performed with the open approach or may be performed through suction-assisted procedures or liposuction. This involves the use of liposuction cannulae to remove the fat deposits. When suction-assisted lipectomy is performed alone, not as part of another procedure, for the removal of excessive skin, it is considered cosmetic in nature and not medically necessary.

Significant weight loss may result in the presence of redundant skin. This is one of the most common complaints of patients seeking excision of excessive skin and fat. Procedures for removal of redundant skin in the extremities and after weight loss are often performed in conjunction with other procedures, such as an abdominoplasty and/or panniculectomy procedure.

The presence of massive redundant or excessive skin, in rare situations, may result in chronic and persistent local skin conditions in the skin folds. These conditions may include intertrigo, intertriginous dermatitis, cellulitis, ulcerations or tissue necrosis, or they may lead to painful inflammation of the subcutaneous adipose tissue. When these skin conditions are severe, there may be interference with activities of daily living, such as personal hygiene and ambulation. In addition to excellent personal hygiene practices, treatment of these skin conditions generally involves topical or systemic corticosteroids, topical antifungals, and topical or systemic antibiotics.

Labiaplasty
Labiaplasty, or labia reduction (Current Procedural Terminology [CPT] codes 15839 or 56620), is a surgical procedure that removes tissue from the labia, and/or reshapes the labia. The procedure may be performed for asymmetrical, enlarged, or hypertrophic labia minora and/or labia majora. In general, labiaplasty is performed for reduction of labia minora; however, the procedure may also involve labia majora. The procedure is generally cosmetic in nature and is performed to improve appearance. The diagnosis of labia minora hypertrophy is a clinical one and the diagnosis is based upon the presence of symptoms and/or distress associated with labia minora that are within the size range considered hypertrophic (Laufer, 2020). There are no standard diagnostic criteria for labia minora hypertrophy. Clinicians generally use labial width (measurement of medial-lateral axis of the labia minora when gently stretched to full width) measurements. There does not appear to be standards for normal labial width, and there can be a wide variation in what is considered normal. A stretch width of greater than six cm is generally felt to be consistent with hypertrophy (Laufer, 2020).

In situations where there is discomfort from the condition, the documentation by the provider should include if there are signs of chronic irritation such as skin abrasions, redness, or hyperkeratosis. These symptoms can usually be managed with non-surgical measures including: personal hygiene measures (such as use of emollients), supportive garments, arrangement of labia minora during exercise and other activities, and avoidance of form-fitting clothes.

Vulvectomy (CPT code 56620) is a surgical procedure where part or all of the vulva is removed. A simple, complete vulvectomy includes removal of all of the labia majora, labia minora, and clitoris, while a simple, partial vulvectomy may include removal of part or all of the labia majora and labia minora on one side and the clitoris. The removal of vulvar tissue (vulvectomy or partial vulvectomy) may be considered medically necessary for diagnosis or treatment of benign, premalignant or malignant lesions.

In the absence of the above conditions vulvar surgery performed to change the appearance or reduce the size of the labia would be considered cosmetic as well as not medically necessary.

(For information regarding a labiaplasty procedure as part of initial gender reassignment surgery, refer to the CIGNA Medical Coverage Policy: Treatment of Gender Dysphoria)

Professional Societies/Organizations
American College of Obstetricians and Gynecologists (ACOG): ACOG published a Committee Opinion for Elective Female Genital Cosmetic Surgery (ACOG, 2020). Recommendations and conclusions include:

- 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.
- Obstetrician–gynecologists should have sufficient training to recognize women with sexual function disorders as well as those with depression, anxiety, and other psychiatric conditions. Individuals should be assessed, if indicated, for body dysmorphic disorder. In women who have suspected psychological concerns, a referral for evaluation should occur before considering surgery.
- In responding to a patient's concern about the appearance of her external genitalia, the obstetrician–gynecologist can reassure her that the size, shape, and color of the external genitalia vary considerably from woman to woman. These variations are further modified by pubertal maturity, aging, anatomic changes resulting from childbirth, and atrophic changes associated with menopause or hypoestrogenism, or both.

American College of Obstetricians and Gynecologists (ACOG): ACOG published a Committee Opinion for Breast and Labial Surgery in Adolescents (ACOG, 2017; 2020). Recommendations include:

- The obstetrician-gynecologist caring for adolescents should have good working knowledge of nonsurgical alternatives for comfort and appearance as well as knowledge of indications and timing of surgical intervention and referral.
- 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.

The opinion also notes that, "
When adolescents seek medical treatment, the first step is often education and reassurance regarding normal variation in anatomy, growth, and development. Nonsurgical comfort and cosmetic measures may be offered, including supportive garments, personal hygiene measures [such as use of emollients], arrangement of the labia minora during exercise, and use of formfitting clothing. 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. 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."

Use Outside of the US
No relevant information

Medicare Coverage Determinations

	Contractor	Policy Name/Number	Revision Effective Date
NCD		No National Coverage Determination found	
LCD	Novitas Solutions	Cosmetic and Reconstructive Surgery (L35090)	11/2019
LCD	Palmetto GBA	Cosmetic and Reconstructive Surgery (L33428)	10/2019
LCD	Wisconsin Physcian Services	Cosmetic and Reconstructive Surgery (L34698)	1/1/2021
LCD	Noridian Healthcare Solutions	Plastic Surgery (L35163)	

Note: Please review the current Medicare Policy for the most up-to-date information.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
15819	Cervicoplasty
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
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
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839†	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

†**Note: Considered cosmetic/not medically necessary when used to report labiaplasty**

Suction-assisted lipectomy

Considered Cosmetic/Not Medically Necessary when performed alone and not as part of a medically necessary procedure:

CPT®* Codes	Description
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

Rhytidectomy for glabellar frown lines:

Considered Cosmetic/Not Medically Necessary:

CPT®* Codes	Description

15826	Rhytidectomy; glabellar frown lines

Labiaplasty

Considered Cosmetic/Not Medically Necessary when used to report labiaplasty:

CPT®* Codes	Description
56620	Vulvectomy, simple; partial

***Current Procedural Terminology (CPT®) ©2020 American Medical Association: Chicago, IL.**

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