



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an independent  
Licensee of the Blue Cross and Blue Shield Association

## Medical Policy

### Suction Lipectomy for Lipedema

#### Table of Contents

- [Policy: Commercial](#)
- [Policy: Medicare](#)
- [Authorization Information](#)
- [Coding Information](#)
- [Description](#)
- [Policy History](#)
- [Information Pertaining to All Policies](#)
- [References](#)

#### Policy Number: 043

BCBSA Reference Number: 7.01.80 (For Plan internal use only)

NCD/LCD: N/A

#### Related Policies

Plastic Surgery, #068

Surgical Debulking of Lymphedema

#### Policy

### Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue<sup>SM</sup> and Medicare PPO Blue<sup>SM</sup> Members

Liposuction/excision/debulking for the treatment of lipedema may be considered **MEDICALLY NECESSARY** when all of the criteria are met and clinical documentation in medical record is available including photographs

1. Diagnosis of lipedema in the limbs or trunk as evidenced by all of the following:
  - Bilateral, symmetrical, disproportionate fatty tissue hypertrophy on the limbs based as evidenced by clinical documentation and photographs, AND
  - Evidence of cuff phenomenon (sparing of feet (if lower extremities are affected) and hands (if upper extremities are affected), AND
  - Pain and/or hypersensitivity to touch in lipedema affected areas; AND
  - Absence of pitting edema (no "pitting" when finger or thumb pressure is applied to the area of fat) (unless there is comorbid lymphedema), AND
  - Negative stemmer sign, AND
  - Documented significant physical functional impairment, e.g., difficulty ambulating or performing activities of daily living, or medical complications such as recurrent cellulitis or skin ulcerations; AND
  - Failure of limb adipose hypertrophy to respond to recommended bariatric surgery or other medically supervised weight loss measure, if class II or III obesity, AND
2. Refractory to 6 or more months of conservative medical management such as medical grade compression garments as recommended by a compression specialist, complex decongestive lymphatic therapy (also referred to as manual lymph drainage), intermittent sequential pneumatic compression, AND

3. Evaluation by the referring primary care provider or a vascular/endocrine specialist confirms that lipedema is an independent cause of functional impairment and surgery is expected to restore or improve function impairment, AND
4. Surgical treatment is performed by a hospital credentialed, board certified plastic surgeon.

Liposuction for lipedema may need to be completed in stages when the total volume of liposuction exceeds clinical standards of 5000cc total aspirate during the initial procedure and may be considered **MEDICALLY NECESSARY** when expected to be completed within a 12 month period.

Repeat treatment of lipedema with liposuction in areas that have been fully treated is considered **INVESTIGATIONAL**.

Liposuction for lipedema for cosmetic reasons is considered investigational **INVESTIGATIONAL**

Preventative treatment of lipedema with liposuction is considered **NOT MEDICALLY NECESSARY**.

### Prior Authorization Information

#### Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

#### Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization <b>is</b> required.
Commercial PPO and Indemnity	Prior authorization <b>is</b> required.
Medicare HMO Blue <sup>SM</sup>	Prior authorization <b>is</b> required.
Medicare PPO Blue <sup>SM</sup>	Prior authorization <b>is</b> required.

### CPT Codes / HCPCS Codes / ICD Codes

*Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.*

*Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.*

*The following codes are included below for informational purposes only; this is not an all-inclusive list.*

**The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:**

#### CPT Codes:

CPT codes:	Code Description
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
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

**According to the policy statement above, the following CPT codes are considered investigational for the conditions listed for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:**

**CPT Codes:**

CPT codes:	Code Description
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
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk

**Description**

Lipedema is a rare and progressive disease of subcutaneous lipodystrophy resulting in an overgrowth of fat deposits in the buttocks, hips and limbs. In some patients, overgrowth of fat deposits can compromise the lymphatic system, resulting in co-occurrence of lymphedema with lipedema (lipolymphedema). Lipedema primarily affects females and is typically found to affect extremities bilaterally, lower extremities much more often than upper. Diagnosis of lipedema is based on physical characteristics including bilaterally symmetrical overgrowth in the extremities, distinction between normal and abnormal tissue at the ankle (“cuff” syndrome) and lack of overgrowth typically in the hands, feet, and trunk. Patients often report pain when pressure is applied to area of overgrowth and fat deposits as well as easy bruising in these areas. Lipedema can also affect mobility. Magnetic Resonance Imaging studies demonstrated that the subcutaneous fat appears normal but is disproportionately larger compared to other bodily areas.

Lipedema is classified into four stages by the lipedema foundation<sup>1</sup>:

1. Stage 1 characterized by smooth skin with an increase of enlarged subcutaneous fat tissue
2. Stage 2 characterized by uneven skin with indentations in the fat tissue and larger mounds of fat tissue (lipomas) able to be seen and felt
3. Stage 3 characterized by large extrusion of fat tissue causing deformations especially on the thighs and around the knees
4. Stage 4 characterized by development of lipolymphedema, a condition where both lipedema and lymphedema are present in the same body region with large overhangs of tissue on legs and/or arms.

Lipedema does not respond to normal weight loss interventions and treatment consists of conservative measures to reduce lower extremity symptoms, disability, and functional limitations, to improve quality of life and prevent disease progression. The primary focus of treatment is weight normalization (if coexisting obesity is present), exercise, and decongestive lymphatic therapy. Liposuction has been proposed as a surgical treatment option for lipedema. Lipedema is often misdiagnosed as obesity or lymphedema. The pathophysiology of lipedema is unknown. Diagnosis is determined by clinical and physical findings alone, as there is no diagnostic test available.

Liposuction for lipedema in an extremity or the trunk may need to be completed in stages when the liposuction volume exceeds clinical standards for one surgery (>5000 cc total aspirate).

**Summary**

For individuals who are undergoing suction lipectomy for lipedema of the extremities, the evidence includes single-arm studies, case studies, consensus articles, and review articles. Additional publications not in the English language were identified but not reviewed. All studies used patients as their own controls and none of the studies compared outcomes with patients treated with decongestive therapy

alone. Studies reported improvements in pain, function, and decreased need for decongestive therapy following liposuction.

In 2016, Baumgartner et al., published success rates for 85 patients who underwent liposuction treatment for lipedema at 4 and 8 years which demonstrated improvements in pain, sensitivity to pressure, bruising and functional impairments. Most patients showed similar results at the 8 year follow up compared to the initial 4 year outcome data. Most patients who had recurrence of bruising or restricted movement were between 50-60 during the initial surgery demonstrating the importance of surgical intervention in earlier stages of lipedema and in younger populations. In a follow up study at 12 years, 60 patients reported sustained improvements and overall positive outcomes similar to the 4 and 8 year measures. The study demonstrated permanent reductions in symptom severity and continued improvements in quality of life for most patients evaluated.

Wollina and Heinig (2019) reported a consecutive series of patients who had failed conservative therapy for at least 6 months. In this series, 43% of patients had stage III lipedema and follow-up by clinician interview was provided for all patients at a median of 2 years. The range of follow-up was wide. Patients reported a substantial improvement in pain on a 10 point VAS and minor to marked improvement in mobility and bruising using a 3 point scale. A strength of this study is the inclusion of consecutive patients with advanced lipedema who had previously failed conservative therapy. Limitations of this study include the potential for bias in responses to clinician interview, lack of a control group treated by continued decongestive therapy, and the limited duration of follow-up.

A 10 year retrospective, before and after study for multistage liposuction for lipedema by Kruppa et al, (2022) found that liposuction was an effective surgical option for reducing symptoms and reducing the need for potential future surgeries especially when performed in patients with lower body mass index scores or early stage diseases. A 35.7% reduction in complex decongestive therapy score was found in 106 patients who underwent large volume liposuction (mean lipoaspirate, 6355 ± 2797 ml) after 20 months. Patients reported improvement in lipedema associated symptoms including pain and functional impairments.

Given the study limitations described above, the policy is based primarily on clinical practice guidelines and recommendations as well as national standards of care. Randomized controlled trials looking at outcomes of patients undergoing Liposuction as primary method versus decongestive therapy are ongoing.

### **Clinical Practice and Professional Society Guidelines**

The American Society of Plastic Surgeons (ASPS) has not published clinical practice guidelines for treatment of lipedema. However, they state that certain measures should be taken to ensure proper patient care and quality and safety with use of liposuction. To ensure only providers with appropriate training and expertise are credentialed, the ASPS recommends the following:

- Plastic surgery training or other formal training in liposuction methods that is recognized as sufficient by a governing medical body (e.g., American Board of Medical Specialties)
- Liposuction training as part of board-specific requirements and maintenance of certification activities
- Hospital admitting privileges

The 2003 Practice Advisory indicated that large volume liposuction (greater than 5,000 cc total aspirate) should be performed in an acute-care hospital or in a facility that is either accredited or licensed. Large volume procedures should be done in stages if the total volume is greater than 5,000 per procedure and patients should wear compression garments and stockings for several weeks postoperatively as recommended by surgical team and compression specialists.

In 2021, a consensus standard of care guideline was published by a U.S. committee of lipedema experts (Herbst, 2021). The standard of care guideline indicates that conservative (non-surgical) therapies for lipedema may help slow progression and possibly relieve symptoms but are not curative. These include nutritional guidance and weight loss programs. Long term outcomes of non-surgical and surgical treatments demonstrated improvement in quality of life and overall symptoms including reducing pain,

increasing mobility and ambulation, and improving gait. Reduction surgery for lipedema is the only approach that can restore functional impairments and should be done before complications and disabilities occur. In the case of lipolymphedema, compression garments, decongestive lymphatic therapy (also referred to as manual lymph drainage) and intermittent sequential pneumatic compression may also provide a benefit to improve mobility, stance, and gait, and reduce pain. The evidence is sufficient to improve overall net health outcomes for liposuction for the treatment of lipedema in the extremities.

## Policy History

Date	Action
5/2024	New medical policy describing ongoing medically necessary and investigational indications. 5/1/2024.

## Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

## References

- Herbst, K., Kahn L., Iker, E., et al. Standard of care for lipedema in the United States. 2021 Dec 36(10) 779-796. doi: 10.1177/02683555211015887. Epub 2021 May 28.
- Schlosshauer T, Heiss C, von Hollen AK, et al. Liposuction treatment improves disease-specific quality of life in lipoedema patients. *Int Wound J*. 2021 May 5. doi: 10.1111/iwj.13608. Epub ahead of print.
- Herbst KL, Hansen EA, Cobos Salinas LM, et al. Survey Outcomes of Lipedema Reduction Surgery in the United States. *Plast Reconstr Surg Glob Open*. 2021 Apr 23;9(4):e3553.
- Dadras M, Mallinger PJ, Corterier CC, et al. Liposuction in the Treatment of Lipedema: A Longitudinal Study. *Arch Plast Surg*. 2017 Jul;44(4):324-331.
- Forner-Cordero I, Forner-Cordero A, Szolnoky G. Update in the management of lipedema. *Int Angiol*. 2021 Apr 19.
- Atan T, Bahar-Özdemir Y. The Effects of Complete Decongestive Therapy or Intermittent Pneumatic Compression Therapy or Exercise Only in the Treatment of Severe Lipedema: A Randomized Controlled Trial. *Lymphat Res Biol*. 2021 Feb;19(1):86-95.
- Ghods M, Georgiou I, Schmidt J, Kruppa P. Disease progression and comorbidities in lipedema patients: A 10-year retrospective analysis. *Dermatol Ther*. 2020 Nov;33(6):e14534.
- Wiedner M, Aghajanzadeh D, Richter DF. Differential diagnoses and treatment of lipedema. *Plast Aesthet Res* 2020; 7: 10.
- Aksoy H, Karadag AS, Wollina U. Cause and management of lipedema-associated pain. *Dermatol Ther*. 2021 Jan;34(1):e14364.
- Baumgartner A, Hueppe M, Meier-Vollrath I, Schmeller W. Improvements in patients with lipedema 4, 8 and 12 years after liposuction. *Phlebology*. 2021 Mar;36(2):152-159.
- Kruppa P, Georgiou I, Schmidt J, Infanger M, Ghods M. A 10-Year Retrospective before-and-after Study of Lipedema Surgery: Patient-Reported Lipedema-Associated Symptom Improvement after Multistage Liposuction. *Plast Reconstr Surg*. 2022 Mar 1;149(3):529e-541e. doi:
- Georgiou I, Kruppa P, Schmidt J, et al. Liposuction for Lipedema: Functional Therapy or Aesthetic Procedure? *Aesthetic Plast Surg*. 2021 Feb;45(1):212-213.
- Angst F, Lehmann S, Aeschlimann A, et al. Cross-sectional validity and specificity of comprehensive measurement in lymphedema and lipedema of the lower extremity: a comparison of five outcome instruments. *Health Qual Life Outcomes*. 2020 Jul 22;18(1):245.
- Forner-Cordero I, Szolnoky G, Forner-Cordero A, et al. Lipedema: an overview of its clinical manifestations, diagnosis and treatment of the disproportional fatty deposition syndrome - systematic review. *Clin Obes*. 2012 Jun;2(3-4):86-95.

15. Kruppa P, Georgiou I, Biermann N, et al. Lipedema-Pathogenesis, Diagnosis, and Treatment Options. *Dtsch Arztebl Int.* 2020 Jun 1;117(22-23):396-403.
16. Sandhofer M, Hanke CW, Habbema L, 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.
17. Alwardat N, Di Renzo L, Alwardat M, et al. The effect of lipedema on health-related quality of life and psychological status: a narrative review of the literature. *Eat Weight Disord.* 2020 Aug;25(4):851-856.
18. Teven CM, TerKonda SP, Martinez-Jorge J, et al. Liposuction and Patient Safety: Appropriately Credentialing Providers. *Plast Reconstr Surg.* 2021 Jun 1;147(6):1087e-1088e.

---

<sup>i</sup> Expert opinion of the United States standard of care for lipedema