



## Lipedema Treatment

<b>LOB(s):</b> <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid	<b>State(s):</b> <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Oregon <input type="checkbox"/> Washington
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### Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

### Background

Lipedema is a painful, chronic, incurable disease that almost exclusively affects women after puberty and is characterized by abnormal bilateral enlargement of subcutaneous adipose tissue of the legs or arms but with normal hands and feet. Symptoms include painful sensation in the involved limbs, impaired mobility, and disfigurement with lumps under the skin.

Treatment for lipedema is focused on managing the symptoms by reducing volume, inflammation, pain, and restoring or maintaining mobility and slowing disease progression. First line treatment is conservative therapy such as manual lymph drainage, compression garments, and physical mobilization. When symptoms persist and worsen, surgical options such as lipectomy or liposuction may be considered.

### Criteria

#### Commercial

#### Prior authorization is required

##### A. Lipectomy/Liposuction

PacificSource may consider lipectomy and/or liposuction for the treatment of lipedema to be medically necessary when **ALL** of the following criteria is met:

1. Documentation supports significant functional impairment (e.g., difficulty performing activities of daily living) or medical complication (i.e., recurrent cellulitis)
2. When lipectomy and/or liposuction is expected to improve the functional impairment
3. Condition has failed to respond to at least 3 consecutive months of medical management (e.g., conservative treatment with compression garments, manual lymph drainage).

## Medicaid

PacificSource Community Solutions follows Oregon Administrative Rules (OARs) 410-120-1200 and 410-141-3820, 410-141-3825, 410-141-3830 for coverage of Lipedema Treatment in adult members, 21 years and older.

PacificSource Community Solutions (PCS) follows EPSDT coverage requirements in OAR 410-151-0002 through 410-151-0003 for member under the age of 21. Coverage of Lipedema Treatment is determined through a case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in 410-151-0001.

## Medicare

PacificSource Medicare follows Local Coverage Determination for Plastic Surgery L37020

## Coding Information

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The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

- 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
- 15839 Excision, excessive skin, and subcutaneous tissue (includes lipectomy), other area
- 15877 Suction assisted lipectomy; trunk
- 15878 Suction assisted lipectomy; upper extremity
- 15879 Suction assisted lipectomy; lower extremity

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

## Definitions

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**Cellulitis:** An infection that spreads to deep tissues of the skin and muscle, which may cause warmth, tenderness, fever, chills, swollen lymph nodes, and blisters.

**Functional/Physical Impairment:** An impairment which causes deviation from the normal function of a tissue or organ resulting in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities.

**Lipedema:** A chronic disease affecting almost exclusively women after puberty, characterized by painful abnormal enlargement of subcutaneous adipose tissue of the arms and legs.

**Lipectomy:** Lipectomy is a surgical technique that involves the surgical removal of excess subcutaneous adipose tissue that can accumulate as a result of lipedema.

**Liposuction:** Formally known as suction-assisted lipectomy, is a surgical suction procedure performed to recontour the individual's body by removing excess fat deposits that have been resistant to reduction by diet or exercise.

## References

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Oregon Administrative Rules (OARs). Oregon Health Authority. Health Systems: Medical Assistance Programs – Chapter 410  
<https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87>

## Appendix

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**Policy Number:**

**Effective:** 11/01/2022

**Next review:** 12/1/2025

**Policy type:** Enterprise

**Author(s):**

**Depts:** Health Services

**Applicable regulation(s):**OAR 410-120-1200, 410-141-3820, 410-141-3825, 410-141-3830, 410-151-0001, 410-151-0002, 410-151-0003. OARs 410-120-1200 and 410-141-3820 through 3830

**Commercial Ops:** 10/2024

**Government Ops:** 11/2024