PROVIDER POLICIES & PROCEDURES

SURGICAL TREATMENT OF LIPEDEMA AND LYMPHEDEMA

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for surgical treatment for lipedema and lymphedema. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Lipedema is a chronic, progressive adipose tissue disorder characterized by the bilateral and symmetrical abnormal accumulation of subcutaneous fat, primarily in the lower extremities and, in some cases, the upper arms. The condition occurs almost exclusively in females and is distinguished by a disproportionate distribution of fatty tissue that is spared in the hands and feet creating a characteristic "cuffing" appearance at the ankles and wrists.

Lymphedema is a chronic condition characterized by the abnormal accumulation of protein-rich lymphatic fluid in the interstitial tissues, resulting from impaired lymphatic transport capacity due to structural or functional disruption of the lymphatic system. This can cause persistent swelling in one or more extremities and may involve the trunk, head, neck, or genitalia.

CLINICAL GUIDELINE

Coverage guidelines for surgical treatment of lipedema and lymphedema will be made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only.* Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Lipectomy, liposuction, and excision of excessive skin for the treatment of lipedema may be considered medically necessary when all of the following criteria are met:

1. The individual has all of the following physical exam findings:
    a. Bilateral, symmetric disproportionate fat deposition in the lower extremities with sparing of the hands and feet; AND
    b. Ankle cuff sign (an abrupt demarcation of fatty tissue at the ankle with the dorsum of the feet spared); AND
    c. Tenderness to palpation; AND
    d. Pitting edema is absent (unless there is concomitant lymphedema); AND
2. Photographs to support the physical exam findings; AND
3. The individual has a significant physical functional impairment (e.g., difficulty ambulating, performing activities of daily living, or intractable pain); AND
4. The individual has been unresponsive to three (3) or more months of conservative treatment including one or more of the following:
    a. Medical grade compression garments; or
    b. Manual lymphatic drainage; or

c. Intermittent pneumatic compression; or
d. Conservative treatment is contraindicated due to certain conditions (e.g., active infection, a deep vein thrombosis, or congestive heart failure); AND

5. Weight loss efforts have failed to reduce fat distribution in lipedema-affected areas; AND
6. Postoperative care includes the use of compression garments to maintain the surgical benefits.

Excisional procedures (suction-assisted protein lipectomy (SAPL), debulking) for the treatment of stage II or stage III non-pitting lymphedema may be considered medically necessary when the following criteria are met:

1. The individual has been unresponsive to three (3) or more months of conservative treatment including one or more of the following:
   a. Manual lymphatic drainage (MLD); or
   b. Medical grade compression garments; or
   c. Complete decongestive therapy (CDT); AND
2. Photographs supporting the diagnosis of stage II or stage III non-pitting lymphedema; AND
3. The individual has a significant physical functional impairment (e.g., difficulty ambulating, performing activities of daily living, recurrent cellulitis, or intractable pain); AND
4. Postoperative care includes the use of compression garments to maintain the surgical benefits.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Requests for coverage of surgical treatment of lipedema or lymphedema will be reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for surgical treatment of lipedema and lymphedema:

1. Fully completed authorization request via on-line web portal;
2. Clinical documentation as outlined in the *Clinical Guideline* section from the requesting physician, APRN, or PA supporting the medical necessity of the requested procedure;
3. Photographs of the physical examination findings consistent with the criteria outlined in the *Clinical Guideline* section; and
4. Other information as requested.

EFFECTIVE DATE
This Clinical Guideline is effective for prior authorization requests for individuals covered under the HUSKY A, B, C, and D programs on or after November 1, 2026.

LIMITATIONS
N/A

CODES:

Code	Description
15832	Removal of extra skin and tissue of thigh
15833	Removal of extra skin and tissue of leg
15834	Removal of extra skin and tissue of hip
15835	Removal of extra skin and tissue of buttock
15836	Removal of extra skin and tissue of arm
15837	Removal of extra skin and tissue of forearm or hand
15838	Removal of extra skin and tissue of chin
15839	Removal of extra skin and tissue of other area
15847	Extensive removal of extra skin and tissue of abdomen
15876	Suction assisted removal of fat of head and neck
15877	Suction assisted removal of fat of body
15878	Suction assisted removal of fat of arm
15879	Suction assisted removal of fat of leg

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness,

injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

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- Sandhofer M, Hanke CW, Habbema L, Podda M, Rapprich S, et al. Prevention of Progression of Lipedema With Liposuction Using Tumescent Local Anesthesia; Results of an International Consensus Conference. *Dermatol Surg* 2019;00:1-9.doi:10.1097/DSS.0000000000002019
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PUBLICATION HISTORY

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