Medica Central Coverage Policy

Policy Name:	**Liposuction for the Treatment of Lymphedema or Lipedema MP9650**
Effective Date:	**07/01/2025**

Important Information – Please Read Before Using This Policy

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

Coverage Policy

Liposuction is **COVERED** for the treatment of moderate to severe lipedema or moderate to severe lymphedema when condition has not responded to standard conservative treatment (e.g., compression therapy program managed by physician and/or physical/occupational therapist) and the condition is causing significant functional impairment that interferes with activities of daily living.

Liposuction is considered investigative and unproven and therefore **NOT COVERED** for all other lipedema and lymphedema indications. There is insufficient reliable evidence in the form of high quality peer-reviewed medical literature to establish the efficacy or effects on health care outcomes.

Description

Lymphedema is a chronic progressive disease characterized by painful swelling in the extremities (arms and/or legs). The swelling occurs when lymph nodes are no longer facilitating the proper drainage of lymph fluid from an area of the body. Primary lymphedema is a congenital condition. Secondary lymphedema is the most common type of lymphedema. This condition may be caused by infection, trauma or, most commonly, treatment of cancer.

Lipedema is a disorder characterized by the deposit of fat beneath the skin in the arms and legs. The disorder most often affects the lower extremities and almost exclusively occurs in women. The exact cause is unknown, but may be associated with hormonal changes and heredity. Symptoms can include abnormal enlargement of extremities accompanied by pain and easy

bruising which can worsen over time.

Symptoms of both conditions may include pain, skin issues, impaired mobility and difficulty performing activities of daily living. Complete or complex decongestive therapy (CDT) that includes manual lymph drainage, compression therapy, exercise and skin care is considered standard conservative treatment for both lymphedema and lipedema.

Liposuction (suction-assisted lipectomy) is a surgical technique for removal of adipose tissue via a cannula that is inserted subcutaneously to allow for suction removal of the tissue. The four types of liposuction are tumescent (most common), ultrasound-assisted, laser-assisted, and power-assisted. Suction-assisted protein lipectomy (SAPL) is a specialized form of liposuction intended to remove more solid tissue at deeper levels than standard liposuction.

Liposuction is proposed as a treatment option for individuals whose lymphedema/lipedema has not responded adequately to standard conservative treatment.

FDA Approval

Liposuction is a procedure and therefore is not regulated by the FDA. Any medical devices, drugs, biologics or tests used as part of this procedure may be subject to FDA regulation.

Prior Authorization

Prior authorization is not required. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Coding Considerations

Use the current applicable CPT/HCPCS code(s). The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT Codes

- **15878** - Suction assisted lipectomy; upper extremity
- **15879** - Suction assisted lipectomy; lower extremity

	Committee/Source	Date(s)
Document Created:	Medical Policy Committee/Health Services Division	June 21, 2023
Revised:		
Reviewed:		

Medica Central Coverage Policy

Original Effective Date:	10/01/2023
Re-Review Date(s):	02/20/2025
	05/15/2025
Administrative Update:	