The Liposuction for Lipedema Medical Healthcare Carrier Reimbursement Guidebook

Lymph-Sparing Liposuction

by

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*The Liposuction for Lipedema Medical Healthcare Carrier Reimbursement Guidebook*

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by Jeffrey P. Restuccio, CPC, COC, MBA

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**Hold Harmless Statement**

This coding and reimbursement guideline is provided for educational purposes only. It is not intended to represent the only, or necessarily the best, coding advice for the situations discussed, but rather represents an approach, view, statement, or opinion that may be helpful to persons responsible for coding and billing in a medical clinic.

The statements made in this publication should not be construed as policy or procedure, nor as standards of care. Codes and policies change all the time; while every effort was made to ensure accuracy, the author makes no representations and/or warranties, express or implied, regarding the accuracy of the information contained in this book and disclaims any liability or responsibility for any consequences resulting from or otherwise related to any use of, or reliance on, this book.

## Preface

My goal with this guidebook is to provide medical healthcare carrier reimbursement information for liposuction for Lipedema. The procedure has many names: Lymph-Sparing Liposuction, which includes both tumescent liposuction and Water-Assisted Liposuction.

The reason for all the different names is that technically, liposuction for lipedema does not resemble cosmetic liposuction other than the tools are the same. The focus and the technique is very different. And *that* distinction is at the very top of our “ToDo” list. If you can prove that the procedure is reconstructive and medically necessary (and safe) then most carriers will be reimburse you. More on the different names and liposuction types can be found here [[More on Liposuction Types](#_Types_of_Liposuction:)].

This information is for patients, Providers, insurance carriers, researchers, professional associations, and legislators. If you’re a patient and new to the world of reimbursement, coding, and documentation–and find all of this overwhelming I recommend downloading our latest [one-page reimbursement checklist](https://12uh.com/lipoforlipedemareimbursement/one-page-liposuction-for-lipedema-checklist/) available in the Downloads section of the website. If you follow it meticulously with your Providers it should increase your probability of being reimbursed significantly. Also review the [12-Step Reimbursement Plan](#_Twelve-Step_Reimbursement_Plan) in this Guidebook.

You could focus on those two summaries and win most of your cases.

For most of the additional sections in this Guidebook, unless you’re a Provider, professional association, billing specialist, or researcher, the key is just to know that the issue or term *exists*. Don’t feel you have to know *everything* about co-morbidities or the types and stages of lipedema. Just know that there *are* types, stages and co-morbidities and how that fact may impact your probability of being reimbursed.

After extensive research (May 2020) into liposuction for lipedema reimbursement, I found a lot of information is vague, out-of-date, or incorrect. There is a general lack of specificity and specific dates. As a medical reimbursement consultant, auditor, instructor, and certified medical coder I have spent thousands of hours and over twenty-years learning and perfecting my trade. It takes thousands of hours and years of experience to be good at carrier reimbursement for procedures commonly regarded as “not medically necessary.” Words matter; and specificity matters–they can make the difference between an approval and a denial. Concerning clinical expertise, I am not a doctor (but I do play one on TV\*) so I always defer to experts on clinical issues. (Clinicians feel free to make suggestions and [provide feedback](mailto:lipoforlipedemareimbursement@gmail.com)).

Another glaring negative is the lack of editable / computer-readable documents. All of my information will be available on the website: [www.lipoforlipedemareimbursement.com](http://www.lipoforlipedemareimbursement.com) and in MS-Word (.doc) and MS Excel (.xls) format. The goal is providing information that you can customize to your unique situation; cut-and-paste whatever you need into your appeal and overturn your denial.

The Kindle version of this publication is meant more as a marketing channel and introduction; it’s convenient to read on any device, anywhere; but you cannot use the information easily in your pre-authorization and appeal documents. There are hyperlinks to external links.

\*And I was the nerd in sixth grade, in the back of the class, showing everyone how to use the microscope.

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## Introduction

Many Primary Care Physicians are unfamiliar with lipedema and misdiagnosis it. We definitely need more education in the United States explaining what lipedema is, how to diagnosis it and how it is different from edema, obesity, or lymphedema. There is disagreement concerning the most accurate ICD-10 code for lipedema because there is no specific lipedema code in the United States version of ICD-10-CM [[More On Diagnosis Coding Here](#_ICD-10-CM_Codes_For)]. In the ICD-10-CM Index you will find: Lipedema – *see Edema R60.0.*

Many Providers, medical insurance carriers, the public, and even Independent Medical Review Boards (IMRB) still think of and refer to liposuction as *cosmetic*. I would consider this one of our major problems.

Understand that some surgeons may refuse to file or dissuade you from filing a medical claim. (If you’re a surgeon or work in a surgeons’ office *we need you*.) Many clinics will assert liposuction is “never” paid; that’s not true in 2020. Their staff may be unfamiliar with filing claims and appeals. You may have to file the claim and appeal yourself. It is a *lot* of work. The pre-authorization and appeals could take months and even years. But with an average cost of $16,000 per procedure I would hope that many would feel it’s worth the effort.

The reason most claims are not paid is because “they don’t show up.” In other words, no claim was ever submitted. You have to file a claim and the documentation must be exceptional. Not just good–exceptional. If you follow the *Checklis*t I believe that you will be paid by about 85% of carriers. The remaining will appeal you to death–hoping you will give up. They will bring out subject experts and opinions on all available research and conclude the procedure is experimental, investigational, or unproven–and therefore not medically necessary.

Even if your carrier agrees to reimburse for the procedure as medically necessary, you may not be able to find a qualified surgeon trained specifically in liposuction for lipedema *in-network*. Be sure to read your health insurance policy carefully and if they’re not in-network, ask the carrier for an “out of network exception.” The reimbursement may be less for an “out of network” surgeon. Be sure to get all this in writing. Technically a doctor does not need to be a board-certified plastic surgeon to perform liposuction.

Another issue is that most health insurance carriers will reimburse the surgeon at a lower rate than they typically charge self-pay patients. For that reason, the surgeon may not be enthusiastic about filing the claim. It is my hope that a percentage of plastic surgeons, however small, will be willing to help those patients with debilitating lipedema and welcome the opportunity to file medical insurance. Share *this* information with them. (Surgeons, contact me at [lipoforlipedemareimbursement@gmail.com](mailto:lipoforlipedemareimbursement@gmail.com) if you are on our team.)

Another issue is that there are *class-action lawsuits* against medical insurance carriers for non-payment of liposuction for lipedema as experimental, investigational, or unproven (E/I/U). If the case is won, if you filed insurance, you may be eligible for reimbursement (even if the surgery was one to three years prior, for example); however, you won’t be eligible if you *never filed a claim in the first place*. Even if the carrier denies the pre-authorization, I recommend filing the claim anyway, and appealing it at least once.

Not all lipedema patients will be eligible for the surgery. Some patient may have comorbidities–for instance heart problems–and the insurance company will deny the surgery due to the risk to the patient (see the Kaiser Permanente 2014 liposuction for lipedema denial).

In addition to a legitimate concern for the patient’s welfare, the Provider and carrier must also weigh the potential risk for a lawsuit in the event of a bad surgical outcome. If there is even a small potential for an adverse outcome, they will most likely error on the side of caution and deny the claim.

Be sure to include *photographs* in your documentation packet to the carrier (Provider letters and office visit documentation). If your photographs do not illustrate a decrease in function or mobility as result of the disease, then you may not have a strong claim.

**Summary**

1. There is a need for lipedema education: for Primary Care Provides and the public.
2. There is a need for an ICD-10 code specific for lipedema.
3. Liposuction for lipedema is not cosmetic; it is reconstructive and medically necessary.
4. Getting paid by a medical carrier is a lot of work that can take months and even years, but the majority of claims can be won if you have excellent documentation (do your homework beforehand) and do not give up.
5. Carrier reimbursement is an issue; if a carrier pays but the reimbursement is a tenth of what they normally make–for a much more difficult procedure, there is no incentive for the surgeons.
6. Working appeals is difficult for even the best trained and experienced coding/billers; it is more difficult if most of your business is self-pay.
7. Keep it simple; work off the one-page checklist. Use this Guidebook as a reference.
8. In-Network versus out-of-network; read your contract and get an “out-of-network” exception if no qualified surgeon is available In-Network.
9. Not all patients will qualify; those with the greatest decrease in functionality and mobility will be most likely but the patient must be healthy enough for the surgery.
10. Don’t forget photographs! Make the case that this is reconstructive. Follow the reconstructive requirements with every Provider.
11. Even if your pre-authorization and appeals are denied, you may be able to join in class-action lawsuit against the carrier for breach of contract or a bad-faith claim. (I am not a lawyer so seek professional guidance). If a suit is won, you could be eligible for reimbursement–but only if you filed a claim!
12. Did I say don’t give up until you’ve worked every level of appeal? Think of it as a game of chess. Be prepared. Plan and stay focused.

## **Overview: Liposuction for Lipedema**

**Lipedema** is a condition in which there is a pathological deposit of fatty tissue, usually below the waist, leading to progressive leg enlargement. There is no cure for lipedema and it does not respond well to diet and exercise.

**Incidence:** Estimates of the incidence of lipedema range as high as 11% of the post-pubertal female population, which would be approximately 17 million women in the United States (May 2020). Normal fat is 7%-23% for men and 20% to 35% in women w/ normal BMI. Lipedema is widely under and misdiagnosed (often as obesity or lymphedema.) The two ICD-10 codes most often used in the United States are R60.9 and Q82.0 ([More on ICD-10 Here](#_ICD-10-CM_Codes_For)).

**Diagnosis:** There are no diagnostic tests for lipedema; differential diagnosis is based on a physical exam and patient history. There is some research on the value of an MRI and Lymphoscintigraphy (Gould DJ et al, 2019).

**Reconstructive Liposuction:** Care should be taken to refer to liposuction for lipedema as *reconstructive* and never *cosmetic* surgery. In general, use the phrases: Lymph-Sparing Liposuction, Tumescent liposuction or Water-Assisted Liposuction (if that is actually the technique used by the doctor) [See **Types** Below]. *Avoid* using terms such as “contouring”, “improve appearance”, “aesthetic” or “cosmetic liposuction” in all Provider notes and pre-authorization letters.

**Reconstructive Surgery** is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, *or disease*. It is generally performed to *improve function*, but may also be done to *approximate a normal appearance* (This is the American Medical Association (AMA) and the American Society of Plastic Surgeons (ASPS) definition; most insurance companies use a similar definition).

There are numerous **different types** (techniques/modalities) of liposuction. Not all would be considered medically necessary or correct for lipedema. However, the AMA CPT™ codes make no distinction between [liposuction modalities or techniques](#_Types_of_Liposuction:_1) (TLA, WAL™, PAL™, laser). There are four [liposuction/lipectomy CPT™ codes](#_CPT™_Codes_For): 15876, 15877, 15878, and 15879. The medical (CPT™) term for liposuction is *lipectomy.* Later in this document I will make a case for a [new term and a new CPT code](#_Fibro-Lympho-Lipo-Aspiration_(FLLA)) for liposuction for lipedema. It is technical and if you’re not a surgeon or reimbursement specialist I would skip it.

**Medical Necessity:** reconstructive surgery is approved if it is to “improve the function of a malformed body part.” [Medicare National Policy, MAY 2020]. Liposuction will be approved for lipedema if the insurance is convinced it is (1) medically necessary and *not* (3) investigational or experimental or unproven. It must meet *both* hurdles. Some carriers consider “unproven” as separate from investigational or experimental (other carriers combine them all).

“**Unproven therapies** are treatments or procedures that lack significant medical documentation to support their medical effectiveness.”–Oxford Health (United Healthcare

**Documentation:** It is imperative that Providers use verbiage that explains/reinforces that liposuction for lipedema is uniquely a reconstructive surgery determined by medical necessity. See the detailed documentation recommendations in my [12-Step Reimbursement Plan](#_Twelve_Step_Reimbursement) and [Checklist](#_Reimbursement_Checklist_(LS-TL)).

**Selected Research Outcomes:** Liposuction at this time [2014] is the only method that we know of to remove the lipedema fat. Diet and exercise can reduce "normal" fat but the lipedema fat remains even after bariatric surgery. Research shows lymph-sparing liposuction yields good long-term results in reduction of lipedema pain and in stopping the progression of lipedema (*Liposuction-The Cure for Lipedema Fat*) (Cornely et al., 2006; Schmeller et al., 2006; Warren et al., 2007; Rapprich et al., 2011, 2012).

Tumescent liposuction is the only effective treatment for an incurable disease [lipedema] of unknown etiology to reduce patient pain, improve their quality of life, reduce psychological stress, and improve overall severity score (Rapprich 2010) and prevent progression of the disease and expensive treatment.

The need for conservative therapies such as Manual Lymphatic Drainage (MLD), combined decongestive therapy (CDT), and compression stocking care are greatly reduced in almost all patients, and in some cases, conservative therapies can be eliminated, after lymph sparing liposuction [Karen Herbst blog, 2014].

**Emphasize the dangers of non-treatment** Due to the development of secondary lymphedema and the irreversible damage to the lymphatic system that occurs in later stages of the disease, liposuction should be implemented as part of the standard therapy for lipedema at *early stages*. This will prevent disease progression, improve quality of life, and reduce the need for decongestive therapy. Be sure to include Provider documentation and research to support this.

**Healthcare Policy Denials:** Healthcare carriers range from detailed policies concerning liposuction for lipedema to *no mention* of liposuction or lipedema anywhere in their manual. Some will list liposuction under cosmetic; others under experimental, investigative or unproven, and others it is nowhere to be found. My goal, with feedback from patients, Providers and insurance carriers is to increase significantly the number of carriers acknowledging liposuction for lipedema as reconstructive and reimbursable in 2020.

The Twelve-Stop Plan, next contains a lot of the same information in this overview but organized in outline format.

## Twelve-Step Reimbursement Plan

1. Education/brief overview of lipedema
   1. Lipedema is a condition in which there is a pathological deposit of fatty tissue, usually below the waist, leading to progressive leg enlargement.
   2. There is no cure for lipedema.
   3. Lipedema does not respond well to diet and exercise.
   4. Liposuction is the only available treatment for lipedema after all conservative measures have been exhausted.
2. Document the procedure as reconstructive
   1. Confirm and document that “Lymph-Sparing Liposuction is reconstructive and not cosmetic. Emphasize it is to:
      1. Improve/restore to normal function (mobility).
      2. Address *pain* and bruising issues (use quantitative scores).
      3. Restore to a *normal* appearance.
      4. Improve *Quality Of Life* (QOL).
   2. Address any *comorbidities* (pre-existing conditions).
   3. Include photographs! This is *very* important. They must illustrate decreased functionality, mobility, and gait.
   4. *Do not* include the psychological benefits from the procedure. This is statutorily documented in numerous policies as “not supporting medical necessity.” No matter how important you feel it is, skip it.
3. Hurdles
   1. Most everyone still thinks of liposuction as merely cosmetic. This includes the general public, physicians, insurance companies and even medical review boards (IRB). For that reason I use the phrase: Lymph-Sparing Liposuction.
   2. Understand that some surgeons may refuse to file or dissuade you from filing a claim. Many will assert it is “never” paid; that’s not true. Their staff may be unfamiliar with appeals. You may have to file the claim and appeal yourself.
   3. You may not be able to find a qualified surgeon trained specifically in liposuction for lipedema *in-network*. You need to ask your Provider and the carrier for an “out of network exception.”
   4. Not all carriers, carrier review boards, or provider reps are made equal; some will be much more knowledgeable than others. You won’t win every appeal; some will be incredibly difficult to appeal and others much easier.
   5. Not every lipedema case will warrant payment; if you have co-morbidities, or if impairment to function and mobility cannot be illustrated, you may not be eligible.
4. Medical Necessity
   1. Get letters and a confirmed diagnosis of lipedema from all your Providers: primary care physician, plastic surgeon, cardiologist, endocrinologist, orthopedic doctor, podiatrist, and anyone else who can help document and prove the medical necessity of the procedure. Be sure to focus on: Restore to a Normal Appearance, Improve Function, Quality of Life, and Co-morbidities.
   2. Note that in the 2020 ICD-10-CM there is no specific code for lipedema. Therefore there are multiple codes used to indicate lipedema in the United States [[More on ICD-10](#_ICD-10-CM_Codes_For)].
5. Provide evidence that liposuction for lipedema is not experimental, investigative, or unproven (E/I/U).
   1. Confirm and support liposuction for lipedema as E/I/U *(*not medically necessary).
   2. Note that unproven can be defined differently than the other two above ([Referenced Earlier](#_Overview:_Liposuction_for_1)); many carriers have different Definitions Of E/I/U.
6. Read your insurance contract/plan
   1. Read your carrier manual or contract for cosmetic exclusions, definitions and *Evidence of Coverage* information. Scour it for the terms liposuction and lipedema.
   2. Determine if there is a specific reference to liposuction *for* lipedema. Some carriers don’t reference liposuction at all; others don’t reference it in regard to lipedema.
7. File Your Claim
   1. File the medical insurance claim. Ask the clinic to obtain a pre-authorization and get either a denial reason or approval. Even if they deny the pre-authorization, if you feel you have a good reconstructive, medically necessary case, I would file the claim.
8. Appeal the Denial
   1. Expect to be denied at least once. Most carriers have multiple appeal levels (Medicare has specifically five levels).
   2. I have included an entire set of appeal letters and documents, in Word .doc format on the [website](http://www.lipoforlipedemareimbursement.com) so you can cut and paste and edit to suit your unique needs.
9. Research to support Medical Necessity
   1. Include all relevant research to support liposuction for lipedema as constructive and medically necessary.
   2. Be aware of [common reasons for dismissing research](#_Research_and_How): findings not consistent, lack of a comparator group, small patient size, loss of patients to long-term follow-up, and unproven procedure.
   3. Map your research verbiage to the carrier’s denial, experimental and investigational policy. If they state, “The evidence should consist of well-designed and well-conducted investigations” then state in your appeal that “xyz research is well-designed and well-conducted.”
   4. Always use *quantitative measures* for pain and functionality when available (pain on a 10-point Visual Analogue Scale [VAS]). Use this to indicate severity and potential for improvement.
10. Co-Morbidities
    1. Address comorbidities (pre-existing conditions) and any safety issues that may preclude this patient as a candidate for the surgical procedure.
    2. In one appeal denial (Kaiser, 2014) the argument was simply that the surgeon did not effectively address the potential harm to the patient (even potential death) and that the risk did not warrant the procedure.
11. Associations / Key Opinion Leaders
    1. Please feel free to share this information with lipedema associations and everyone involved with lipedema. Encourage them to change/add verbiage on their website and papers to reflect the procedure as reconstructive and medically necessary.
12. Expert Opinions / Comparables
    1. I have included an expert opinion template in the Appendix. This is for your doctor. I will be posting a list of insurance companies that pay or deny liposuction for lipedema.
    2. One secondary argument is using [*comparable procedures*](#_Comparable_Reconstructive_Procedure) (breast reconstruction, panniculectomy [tummy tuck] and cleft palate repair) to liposuction for lipedema. These procedures have all been historically denied as cosmetic at one time. Most are now reimbursed as reconstructive and medically necessary (lots of exceptions, though).
    3. *Breast reconstruction* is reimbursed nationwide primarily based on federal and state statutes*; cleft palate surgery* is mandated in about 15 states; the tummy tuck (panniculectomy) procedure is most similar to liposuction as most carriers consider it cosmetic, deny it–but if you can prove that it’s reconstructive–on appeal some will pay for it.

If all appeals fail, the last resort is a *legal, class-action lawsuit* against the carrier (California is a good place to start) based on “bad-faith” and breach of contract. Contact a reputable healthcare attorney familiar with breach-of-contract cases (and liposuction for lipedema) in your state.

The Checklist is similar to this document but organized so you check off each action. One-page and two-page versions are available on the Website.

## Reimbursement Checklist Summary

1 I recommend downloading the latest checklist in Microsoft Excel format from the website. It is longer. Read the following checklist very carefully. Proper planning will increase the probability that your healthcare insurance carrier will reimburse for the liposuction procedure. We do not want to give them any reason to deny the claim. Not every item below will apply to every patient.

2 Preparation begins 6-12 months before the surgery. Your goal is to line up everything to make the most compelling case about the severity and uniqueness of your situation and that no other alternative is available.

3 The key to reimbursement is confirming and documenting that Lymph-Sparing Liposuction is reconstructive, medically necessary and not experimental, investigative, unproven, or cosmetic.

4 [ ] All health plans have an appeals process that you need to follow. Be sure to carefully research your plan.

5 [ ] Check in your state if there is a commissioner or ombudsman that assists with healthcare appeals.

6 [ ] Read your carrier manual for exclusions, definitions, and Evidence of Coverage information related to liposuction or lipedema.

7 [ ] File the medical insurance claim [Ask Clinic to obtain and pre-authorization and approval or a denial reason].

8 [ ] If denied you must appeal; most carriers have multiple levels of appeal (Medicare has five levels). Prepare to appeal multiple times over a period of months. Some appeals take over a year.

9 [ ] If all levels of appeal fail, the last resort is a class-action legal suit against the carrier (California is best).

10 [ ] Always get the name, ID number, date/time and e-mail of everyone you speak to during the pre-authorization/appeal process.

11 [ ] If you get an approval, you might want to ask for their supervisor's name (and e-mail). Ask if you can confirm the approval with an e-mail to the patient representative and copy his/her boss.

12 [ ] It is not uncommon to obtain a pre-authorization only to be charged or the insurance company changes their mind later. Document everything meticulously.

13 [ ] Get letters of medical necessity and a confirmed lipedema diagnosis from your primary care doctor and surgeon.

14 [ ] Document the lipedema stage even though the US ICD-10-CM currently does not have lipedema stage codes.

15 [ ] In your documentation packet include a short overview of lipedema and the unique nature of it.

16 [ ] Document progression of the disease and treatment.

17 [ ] Document at least six months of conservative treatment. This is REQUIRED! Your appeal will fail if this is not correctly and carefully documented. Include:

18 [ ] Demonstrate with Provider letters that all conservative treatment has failed and the progression of the disease will worsen without surgical treatment. [ ] Document and quantify all efforts concerning weight loss and obesity.

19 [ ] Include all physical exam notes, labs, test, and relevant surgical operative reports.

20 [ ] All Providers must document that the patient has been compliant in regard to office visits and medical care.

21 [ ] Address comorbidities and any safety issues concerning treatment (risks for surgery). Important!

22 [ ] Obtain notes and documentation from multiple Providers. For specialists this would include consultation reports.

23 [ ] Doctors should include: [ ] Primary Care Provider, [ ] Liposuction Surgeon, [ ] Cardiologist (important to rule-out co-morbidities), [ ] Endocrinologist (address progression, lymphedema, diabetes). [ ] Orthopedic Provider (good for justifying medical necessity for increased functionality). [ ] Podiatrist (focus on gait and mobility).

24 [ ] Photographs are important! Illustrate issues with functionality, mobility, and restoration to a normal appearance.

25 [ ] Adherence to a low carbohydrate diet [either ketogenic diet or the more balanced anti-inflammatory diet] exercise.

19.5 [ ] Document the patient's strict compliance with all treatment and therapy recommendations including: [ ] Compression stocking care. [ ] Combined decongestive therapy (CDT). [ ] Manual Lymphatic Drainage (MLD). [ ] Lymphedema therapy

27 [ ] Establish need for liposuction: Include an over-all quantitative pain and severity score if possible. EQ-5D VAS (Visual analogue scale) is one example. Focus on the following four areas: [1] Improve functionality (explain how, what). [2] Increase mobility and gait. [3] Improve Quality of Life (pain, bruising, migraines) Include quantitative measures if available). [4] Restoring the patient to a normal appearance\*" (Where, what, how).

28 [ ] Migraines, hypothyroidism, diabetes, obesity, [migraine reduction after surgery - (Bauer A et al, 2019)]

29 [ ] The scientific evidence must support conclusions concerning the effect of liposuction on health outcomes.

30 [ ] Lymph sparing liposuction improves the net health outcome. 31 [ ] Lymph sparing liposuction is as beneficial as any established alternatives. 32 [ ] The health improvement is attainable outside the investigational setting. 33 [ ] Include research to support liposuction for lipedema as reconstructive and medically necessary.

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## Frequently Asked Questions (FAQ)

This document is an *adjunct* to [Overview: Liposuction for Lipedema](#_Overview:_Liposuction_for);a lot of the information is similar except it is formatted differently and the slant here is to specifically address questions.

**Q: Isn’t Lipedema** **the same as Obesity?** No, it is a condition in which there is a pathological deposition of fatty tissue, usually below the waist, leading to progressive leg enlargement. Lipedema is often misdiagnosed as simply obesity or lymphedema. There is *no cure for lipedema* and *it does not respond well to diet and exercise.*

**Q: Isn’t Liposuction a Cosmetic Procedure?** I just read on a board-certified surgeon’s website that “liposuction is a cosmetic procedure and *never* reimbursed by medical insurance.” I would think they know more than you!

**Answer:** That is absolutely not true. Many of those posts are many years old. Performing a procedure has nothing to know with the dozens of issues regarding coding, documentation, carrier policies and reimbursement. Most people simply think of liposuction as a cosmetic, body-contouring procedure. It is *not* in the Medicare fee schedule (no RVU’s) which means there is no generally-accepted reimbursement value for the four liposuction codes. Most doctors are not familiar with and do not confirm a lipedema diagnosis, and finally some surgeons either don’t know how *or* don’t *want to* file medical insurance for the procedure: they will earn less from medical carrier reimbursement.

**Old Habits die Hard:** Websites, doctors, associations, blogs, and the general public general think of and refer to liposuction as an “aesthetic” and cosmetic procedure. But, specifically for a diagnosis of lipedema, it *is reconstructive*. This has very important legal and reimbursement implications.

**Q: I was told that all/most carriers won’t pay so why bother filing a claim?** Three reasons: one is that some carriers (Anthem) have a payment policy [AUG 2020], others have paid, and as I mentioned in the [Introduction](#_Introduction), you may be entitled to reimbursement as a result of a class action lawsuit against the carrier.

Also you may need to file at least one appeal (I recommend at least two; Medicare has five levels of appeal.). Those who have won appeals typically win after the second attempt.

**Q: What is Medical Necessity?** This has connotations clinically and administratively. In terms of reimbursement any medical service or procedure must be supported by medical necessity (the conditions or disease, severity, and progression) to support the use of the procedure (clinically) and subsequent reimbursement (administratively) for the procedure. A service may be *medically* warranted for the benefit of the patient (meets medical guidelines) but does not meet a specific *carrier’s* guidelines as being “medically necessary”. That happens all too often. Therefore a service/procedure could be denied as not medically necessary because:

1. It’s not FDA approved (liposuction devices are FDA approved).
2. The patient is too sick for the procedure (comorbidities) and the risk to the patient was not addressed.
3. It is considered Experimental or Investigational (these are generally used interchangeably).
4. Unproven is related to the reason terms above, but some carriers view it differently. For example, a procedure may be used widely and have decades of use, so it would no longer be considered experimental or investigational; the carrier simply doubts the efficacy and value of the procedure for treatment of a particular condition or disease).

**Reconstructive surgery** is approved if it is to “improve the function of a malformed body part.” [Medicare National Policy, MAY 2020]. Liposuction will be approved for lipedema if the insurance is convinced it is (1) medically necessary and not (3) **investigational”** or “**experimental**” or “**unproven**.” It must meet both hurdles. Some carriers (e.g., United Healthcare) consider “unproven” as different from the other two (others don’t).

**Q: What is “investigational” or “experimental” or “unproven?”**

[[Read Long Version Here](#_Experimental/Investigational/Unprov)] Per Blue Cross and Blue Shield Association's Medical Advisory Panel:

“A treatment is considered investigational or experimental when it has progressed to limited human application, but has not achieved recognition as being proven effective in clinical medicine.”

United HealthCare Insurance Company uses an exclusion in its medical policies for treatments it considers “Experimental or Investigational.” The investigational definition merely requires that the treatment have approval from an appropriate regulatory body such as the FDA

**Q: How should the documentation look?**

It is imperative that Providers use verbiage that explains/reinforces that liposuction for lipedema is a reconstructive and that it:

1. **Restores** the patient to a *normal* appearance. [emphasis on restore … to normal]. Use the term “malformed body part” if applicable.
2. **Improves** function [ability to walk, mobility].
3. **Improves** the patient’s quality of life.
4. Based on *evidence-based guidelines and research*, liposuction is the only procedure available after all conservative treatments for lipedema have been exhausted.

You should always have *multiple Providers* submit documentation and a letter. In addition to your Primary Care doctor, you should include your surgeon, your endocrinologist, your cardiologist and a Podiatrist. It must also be documented and demonstrated to the medical insurance company that the patient has completed conservative non-surgical treatment of lipedema *without adequate relief* of their lipedema symptoms. Also demonstrate that *no comorbidities* preclude the surgery.

**Q: What verbiage should I avoid?** Avoid using terms such as “contouring”, “improve appearance”, “aesthetic” or “cosmetic liposuction” in all Provider notes and pre-authorization letters.

I would avoid psychological benefits as most medical health insurance policies specifically state that “feeling better about yourself” is not a valid, medically necessary reason for a procedure. Most cosmetic procedures make “you better feel better.” It is best to avoid that comparison.

Be sure to include pictures and focus on function, mobility, gait, progression of the disease, and the “deformity” of the condition.

**Q: I was told there are no ICD-10 codes for lipedema. Is that accurate?**

Currently (May 2020), There is no [ICD-10-CM diagnosis code](#_ICD-10-CM_Codes_For) specific to Lipedema. After reviewing this problem, I’ve identified three ICD-10-CM codes used in the USA for lipedema. I am working with lipedema experts to submit to the NCHS new ICD-10-CM for consideration in 2021. Each one has its problems.

R60.9 Edema [This is a Sign and Symptom code]

Q82.0 Familial Hereditary Edema [All “Q” codes are considered hereditary/congenital]

E88.2: Adiposis dolorosa; Lipomatosis dolorosa (Dercum’s disease) [An “E” code is an endocrine system code]

I would recommend R60.9 first and Q82.0 second. The E88.2 is related to the German ICD-10 codes but the “dolorosa” are distinctly separate conditions from lipedema. Note how each code is from a different section of ICD-10. Each one has drawbacks–the most important issue here is that we cannot specifically track lipedema as a unique condition. We urgently need a specific code for lipedema.

**Q: I was told to submit the liposuction for lipedema procedure with CPT code 38999 (unlisted procedure, hemic or lymphatic system). Is that correct?**

It has come to my attention (May 2020) that Providers have used this code–and a new name\*–to differentiate the procedure from “cosmetic” liposuction and *have been* reimbursed. Using an unlisted code adds another level of complexity toward obtaining reimbursement. Unlisted codes are rarely reimbursed. There are currently (2020) four liposuction CPT codes: (15876, 15877, 15878, and 15879).They have no Medicare RVU’s (there is no Medicare fee schedule for them). I have information on the new term later in this document.

\* Fibro-Lympho-Lipo-Aspiration (FLLA).

## Lipedema Research Cigna list of Papers

Note that these are listed in the Cigna liposuction for lipedema [*denial* policy](#_Cigna_Denial_Policy). Cigna does not consider liposuction for lipedema to be reconstructive and medically necessary.

1. Sandhofer M, Hanke CW, Habbema L, Podda M, Rapprich S, Schmeller W, et al.; Prevention of Progression of Lipedema With Liposuction Using Tumescent Local Anesthesia; Results of an International Consensus Conference.; Dermatol Surg.; 2019; Jul 23.
2. Hayes, Inc.; Hayes Evidence Analysis Research Brief.; Liposuction for the treatment of lipedema.; 2019; MAR 15, 2019.
3. Wollina U.; Lipedema-An update.; Dermatol Ther.; 2019; Mar;32(2):e12805.
4. Canadian Agency for Drug and Technologies in Health (CADTH).; Rapid Response Report. Summary with Critical Appraisal: Liposuction for the Treatment of Lipedema-A Review of Clinical Effectiveness and Guidelines.; 2019; 7 June.; Accessed July 9, 2019.; Available at URL address: https://cadth.ca/
5. National Institute of Health (NIH).; Lipedema.; 2019; Accessed July 9, 2019.; Available at URL address: https://rarediseases.info.nih.gov/diseases/10542/lipedema
6. Shavit E, Wollina U, Alavi A.; Lipoedema is not lymphoedema: A review of current literature.; Int Wound J.; 2018; Dec;15(6):921-928.
7. Canning C, Bartholomew JR.; Lipedema.; Vasc Med.; 2018; MAR ;23(1):88-90.
8. Hoffner M, Ohlin K, Svensson B, Manjer J, Hansson E, Troëng T, Brorson H.; Liposuction Gives Complete Reduction of Arm Lymphedema following Breast Cancer Treatment-A 5-year Prospective Study in 105 Patients without Recurrence.; Plast Reconstr Surg Glob Open.; 2018; Aug 16;6(8):e1912.
9. Lamprou DA, Voesten HG, Damstra RJ, Wikkeling OR.; Circumferential suction-assisted lipectomy in the treatment of primary and secondary end-stage lymphoedema of the leg.; Br J Surg.; 2017; Jan;104(1):84-89.
10. Halk AB, Damstra RJ.; First Dutch guidelines on lipedema using the international classification of functioning, disability and health.; Phlebology.; 2017; Apr;32(3):152-159.
11. Reich-Schupke S, Schmeller W, Brauer WJ, Cornely ME, Faerber G, Ludwig M, et al.; S1 guidelines: Lipedema.; J Dtsch Dermatol Ges.; 2017; Jul;15(7):758-767.
12. Bellini E, Grieco MP, Raposio E.; A journey through liposuction and liposculture: Review.; Ann Med Surg (Lond).; 2017; Nov 6;24:53-60.
13. Dadras M, Mallinger PJ, Corterier CC, Theodosiadi S, Ghods M.; Liposuction in the Treatment of Lipedema: A Longitudinal Study.; Arch Plast Surg.; 2017; Jul;44(4):324-331.
14. Buck DW 2nd, Herbst KL.; Lipedema: A Relatively Common Disease with Extremely Common Misconceptions.; Plast Reconstr Surg Glob Open.; 2016; Sep 28;4(9):e1043.
15. Warren Peled A, Kappos EA.; Lipedema: diagnostic and management challenges.; Int J Womens Health.; 2016; Aug 11;8:389-95.
16. Baumgartner A, Hueppe M, Schmeller W.; Long-term benefit of liposuction in patients with lipoedema: a follow-up study after an average of 4 and 8 years.; Br J Dermatol.; 2016; May;174(5):1061-7.
17. Okhovat JP, Alavi A.; Lipedema: A Review of the Literature.; Int J Low Extrem Wounds.; 2015; Sep;14(3):262-7.
18. Rapprich S, Baum S, Kaak I, Kottmann T and Podda M.; Treatment of lipoedema using liposuction: Results of our own surveys.; Phlebologie.; 2015; 44(3):121-132.
19. Wollina U, Heinig B, Nowak A.; Treatment of elderly patients with advanced lipedema: a combination of laser-assisted liposuction, medial thigh lift, and lower partial abdominoplasty.; Clin Cosmet Investig Dermatol.; 2014; Jan 23;7:35-42.
20. Reich-Schupke S, Altmeyer P, Stücker M.; Thick legs - not always lipedema.; J Dtsch Dermatol Ges.; 2013; Mar;11(3):225-33.
21. Forner-Cordero I, Szolnoky G, Forner-Cordero A, Kemény L.; 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.; 2012;
22. Schmeller W, Hueppe M, Meier-Vollrath I.; Tumescent liposuction in lipoedema yields good long-term results.; Br J Dermatol.; 2012; Jan;166(1):161-8.
23. Rapprich S, Dingler A, Podda M.; Liposuction is an effective treatment for lipedema-results of a study with 25 patients.; J Dtsch Dermatol Ges.; 2011; Jan;9(1):33-40.
24. Stutz JJ, Krahl D.; Water jet-assisted liposuction for patients with lipoedema: histologic and immunohistologic analysis of the aspirates of 30 lipoedema patients.; Aesthetic Plast Surg.; 2009; Mar;33(2):153-62.
25. Schmeller W, Meier-Vollrath I.; Tumescent liposuction: a new and successful therapy for lipedema.; J Cutan Med Surg.; 2006; Jan-MAR ;10(1):7-10.

## Medical Necessity

This term has different means depending on its usage. Many are inter-related.

**Clinical:** It refers to whether treatment of a disease or condition is warranted medically. This is in regard to published Clinical Practice Guidelines (CPGs) for care for a particular condition. There are clinical guidelines for many conditions including diabetes, IBS, BPH, and chronic pain management; they have nothing to do with reimbursement–but what is medically warranted. High-quality, evidence-informed CPGs offer a way of bridging the gap between policy, best practice, local contexts, and patient choice. The link below includes a list of clinical practice guidelines.

<https://nccih.nih.gov/health/providers/clinicalpractice.htm>

These are important because all medical insurance companies use the strength of the research, and subsequent guidelines related to services and procedures to create reimbursement policy.

**Reimbursement:** Based on the clinical efficacy and outcomes research, medical necessity is what determines if a service or procedure for a specific diagnosis is reimbursed by a medical insurance carrier. Medicare has numerous Local Coverage Determinations (LCD’s) that outline specific procedures and a list of ICD-10 codes that support medical necessity. If a procedure is linked to an ICD-10-CM diagnosis code not on the list the claim will very likely be denied. Some procedures are determined to be cosmetic: the primary goal is to improve appearance or psychological well-being and therefore not considered to be medically necessary.

To be considered reconstructive (and medically necessary) and *not cosmetic*, the procedure must be proven to:

1. Improve or restore normal function, mobility, or gait).
2. Restore the patient to a *normal* appearance.
3. Improve the quality of life (QOL) of the patient.

*Do not* include the psychological benefits from the procedure.

A service or procedure must be determined to *not be* experimental, investigative, or unproven. These terms are also often used as either justifying or not justifying medically necessary.

Another factor impacting whether a procedure or service is medically necessary is whether the patient is *well enough* to tolerate the procedure. If the patient has significant comorbidities then he/she may not be well enough to be approved for surgery based on the “medical necessity” of performing the procedure versus not performing it.

Another coding and documentation use of medical necessity is the selection and use of office visit codes. Per Medicare, medical necessity determines the level *and* frequency of office visit codes. In other words, more complex, worsening, and severe conditions warrant higher level codes and a higher frequency of services than simple and self-limited ones.

**Summary:** Medical Necessity: (1) Clinical justification for a service or procedure; (2) test/lab/procedure reimbursement justification linked to a specific ICD-10 codes; (3) office visit level and frequency justification based on the severity and progression of a disease or condition.

A surgical treatment can be reconstructive and therefore medically necessary. As we have discussed, medical necessity also applies to diagnostic procedures and office visits as well.

## Latest Medical Carrier Reimbursement Information

Please share the information below with your friends, doctors, Facebook, blogs, and other social media. It will be updated frequently [AUG 2020]. It is on my [website](http://www.lipoforlipedemareimbursement.com) so you can cut and paste it into your pre-authorization and appeal documentation. Some of it has already been referenced in this document.

While strictly cosmetic liposuction (to improve appearance) is not reimbursed, reconstructive liposuction (for lipedema, removal of a lipoma, and in conjunction with a panniculectomy) is paid under very strict documentation and patient requirements and guidelines.

If a carrier has a reimbursement policy that still does not address whether there is a surgeon in-network or how much they reimburse. These are both separate but very important issues. They may pay–but only for an in-network surgeon; they may pay but only 1/10 of what the surgeon typically charges. These are important but separate issues.

As of the time of this writing the largest insurance group reimbursing liposuction for lipedema as medically necessary and reconstructive is Anthem-Blue Cross NC00009, Cosmetic and Reconstructive Services Published 11/12/2019.

This policy covers the following 14 states: CA, CO, CT, GA, IN, KY, ME, MO, NH, NV, NY, OH, VA, and WI. It also covers Amerigroup, an Anthem subsidiary providing Medicare Part-C and Medicaid services in the following six states: Arizona, New Jersey, New Mexico, Tennessee, Texas, and Washington. Note that the adjudicators may be unfamiliar with liposuction for lipedema and deny the claim; be prepared to explain the situation and file an appeal. Your documentation must be well organized and perfect.

Numerous Providers, per their websites, claim to have filed medical insurance claims for Lymph-Sparing Liposuction and been reimbursed including: Thomas Wright, MD, CA; Dr David Gruener, NY; Marcia V. Byrd, M.D., GA; Gayle Gordillo, MD, IN; and Dr. David Amron, CA.

In a 2017 review of reimbursement for 27 advanced, disabled lipedema patients who underwent lymph-saving tumescent, liposuction, 6 were approved and 4 were paid after multiple appeals ([about 30%] Source: Aug 2 2017 Fatdisorders.org presentation by doctor Nadiv Shapira on reimbursement).

I have heard from Providers that United Healthcare does reimburse and “some of the blues.” From discussions with liposuction for lipedema reimbursement experts my current conclusion is that regardless of whether there is a policy or not, you can win a majority of the cases if you are eligible (sick enough–but not too sick), motivated enough to get the very best documentation package together, and work multiple appeals–even if it takes a year or more. With that being said, I also think there also some carriers that will never pay you–not matter how good your argument is.

There are currently (May 2020) "Bad Faith / breach of contract" suits in California against about a half-dozen insurance companies on behalf of patients with lipedema who were denied coverage for liposuction. It is expected that most will change their policies as a result and reimburse based on the reconstructive surgery requirements listed above.

Many insurance companies simply have not yet addressed treating lipedema with liposuction. It is not specifically referenced in their Cosmetic and Reconstructive Surgery Policy. My goal, with your help, is to change this in 2020.

There are over fifty, peer-reviewed journal articles reviewing the benefits, efficacy, and safety of tumescent, lymph-sparing liposuction as the only surgical treatment for lipedema. The latest publication at the time of this writing (May 2020), is very favorable regarding Lymph-Sparing Liposuction: *Prevention of Progression of Lipedema With Liposuction Using Tumescent Local Anesthesia*: Results of an International Consensus Conference.

<https://www.ncbi.nlm.nih.gov/pubmed/31356433>

## ICD-10-CM Codes For Lipedema

Currently (May 2020) there is no ICD-10-CM diagnosis code in the United States specific to Lipedema. We are planning to submit a request to the NCHS to adopt the International ICD-10 codes for lipedema, with stages, on June 12, 2020. Essentially it is about a two-page document explaining the clinical need for the new lipedema codes in relation to identification, tracking and research.

If accepted then we will present to the NCHS committee in September 2020 for inclusion in the Oct. 1 2021 ICD-10-CM codes (the 2022 code set). I will be posting our ICD-10-CM presentation on the website. Even if we are selected, it will be about 18 months before the new codes are available–not to mention the education that will be necessary before they are widely used.

After reviewing this problem, I have identified three ICD-10-CM codes used in the USA for lipedema. Each one has its pros and cons. The three, in order of usage, are:

R60.9 Edema

Q82.0 Familial Hereditary Edema

E88.2: Adiposis dolorosa; Lipomatosis dolorosa (Dercum’s disease)

The remaining information is a detailed discussion of current ICD-10-CM code options and the international ICD-10 codes for lipedema, which include stages. If you are not a Provider, reimbursement professional, medical coder or extremely curious, I would skip it and move on to the next section.

An important strategy toward our goal of obtaining widespread medical reimbursement for lipedema as reconstructive would be advocating that the ICD-10-CM committee adopt the German ICD-10 codes for lipedema. The German ICD10 codes for lipoedema (notice the difference in spelling and inclusion of *stages*):

E88.20 Lipoedema, Stage 1

E88.21 Lipoedema, Stage 2

E88.22 Lipoedema, Stage 3

E88.28 Other or unspecified lipoedema

I89.0 Lymphedema, not elsewhere classified (some use this code for lipo-lymphedema).

\* In the United States, we use ICD-10-CM (Clinical Modifications); it is a version of ICD-10 specifically created for use in the United States. While ICD-10 is used internationally, other countries use slightly different data sets.

There are three (3) stages of lipedema. You will find references to Stage IV but many experts don’t agree on the fourth stage. The three are defined as follows:

**E88.20:** **Stage 1** involves an even skin surface with an enlarged hypodermis.

**E88.21:** **Stage 2** involves an uneven skin pattern with the development of a nodular or mass-like appearance of subcutaneous fat, lipomas, and/or angiolipomas.

**E88.22:** **Stage 3** involves large growths of nodular fat causing severe contour deformity of the thighs and around the knee.

***Do not use*** the German ICD-10 codes in the United States (2020); you claim will be rejected; they may be added in a future version of ICD-10-CM.

Even if there are no current codes, the Provider can still *document the stage in* the Impression/Assessment portion of the medical record. The German codes are endocrine codes, so you may have to find an endocrinologist familiar with lipedema to properly document this; do not assume all Providers are familiar with lipedema; you will be surprised how many Primary Care Providers have never diagnosed lipedema or even heard of it. Some Providers may assert that it’s not even a real diagnosis!

In the German lipedema guidelines (S1) (source 1)

**The R60.9 ICD-10 code** is listed in the first page of the S1 German lipedema guidelines.

In online lookups of lipedema I found the following:

<http://smarticd10.health.belgium.be/default.php#!index/2014/D/4183>

In one lookup for lipedema ICD-10-CM\* code, it states:

*Lipedema–See edema.*

See link above

The same is found below

<https://icdlist.com/icd-10/diseases-injuries/term/lipedema>

*Lipedema–See edema.*

See link above

The problem with the note above and code R60.9 is that edema (excessive water) is clearly not lipedema (abnormal fat deposits).

Disease Maps Lists R60.9 as lipedema (Source 2)

<https://www.diseasemaps.org/lipedema/top-questions/icd10-icd9-code/>

**Lipedema R60.9**

Localized adiposity E65.0

Abnormal Weight Gain R63.5

Symptoms involving musculoskeletal and heavy legs R29.8.

**The 3rd Source 3/12/2020 is Lipedemaproject.Org**

R60.9 Lipoedema is listed first.

Q82.0 Familial Hereditary Edemas is listed second.

<https://lipedemaproject.org/lipedema-differential-diagnosis/>

A popular blog below:

<https://lipedemafitness.blogspot.com/2019/12/an-insurance-code-for-lipedema.html>

lists ICD-10-CM code **E88.2** as the closest to lipedema**.** Note that this is related to the German codes except it is a four-character code versus a five-character code. Some consider Adiposis dolorosa to be synonymous with lipedema.

The Lipedema Project list of developers is found at the link below.

<https://www.lipedema.net/Lipedema-Diagnosis.html>

Thomas Wright, M.D., on his website states that there is no code for lipedema and he recommends: **Q82.0**: Acquired Lymphedema and Hereditary Lymphedema (somewhat accurate but also *not lipedema* per Thomas Wright).

In the ICD-10-CM Index the edema code (R60.9) documents the following excludes and includes: Edema, edematous (infectious) (pitting) (toxic) R60.9

Not that each of three suggested codes are from a different *section* of ICD-10.

R60.9 Edema [This is a **Sign and Symptom** code]

Q82.0 Familial Hereditary Edema [All “Q” codes are considered **hereditary/congenital**]

E88.2: Adiposis dolorosa; Lipomatosis dolorosa (Dercum’s disease) [An “E” code is an **endocrine system** code; The German codes are from this group.]

**Bottom Line:** There is no consensus so work with your Provider. All three are options. The ICD-10-CM index *crosswalk* for lipedema is R60.9: edema.

The most important issue here is that without a specific code we cannot accurately track lipedema as a unique condition. We urgently need a specific lipedema code in the United States. Even without a specific code be sure to have your Provider document lipedema and *the stage* in all medical records.

## Lipedema Types

Do not confuse Lipedema stages with lipedema types! There is a difference. The International ICD-10 codes specify stages 1-3 but not types. In contrast to the stage classification, which looks at the condition of the skin and tissue, the **affected areas of the body** are underlined when classifying by type.

Type 1: The subcutaneous fat is increased above all in the area of buttocks and hips, the so-called riding trousers are the result.

Type 2: Lipoedema has spread to the knees, resulting in increased formation of fat on the inside of the knees.

Type 3: The disease now extends from the hips to the ankles.

Type 4: Lipoedema now also affects the arms. The wrists are not affected.

Lipolymphedema is a mixture of lipedema and lymphedema that can develop if a lipedema remains untreated for too long. Most consider this to be secondary lymphedema and reported with code: I89.0.Types of Liposuction: TLA, WAL™, PAL™ and More

This page addresses the specific verbiage I use in this document, the reasoning, and the different *types* of liposuction. Words matter and perception matters. It is imperative that we embark on a long-term strategy to reinforce liposuction for lipedema as reconstructive and a medically necessary procedure and as something separate from *cosmetic* liposuction (which *improves appearance*).

This section is in response to one of my original term: **Lymph-Sparing, Tumescent Liposuction**, which I abbreviated, LS-TL. Some surgeons/researchers considered lymph-sparing to be “marketing” and others felt that Water-Assisted Liposuction is not technically Tumescent. And the latest term recommended is *Fibro-Lympho-Lipo-Aspiration* (FLLA) found in at least one research paper.

You could use the phrase: Lymph-Sparing Liposuction or Water-Assisted Liposuction if that is specifically the instrument the doctor uses and documents. We’ve also discussed using the terms reconstructive liposuction or medically-necessary liposuction. The bottom line is to be *consistent* in all your documentation. Below are several commonly used terms:

**Suction Assisted Lipectomy/Liposuction (SAL):** describes generic liposuction and can be either cosmetic or reconstructive. This is a commonly used acronym and term and the most basic; I would avoid it.

**Tumescent Local Anesthesia** (TLA) is a medical acronym found in several research studies. At the very least use **Tumescent Liposuction.** If your surgeon’s technique/equipment is specifically Water-Assisted Liposuction (WAL) you could specify that. Some WAL users do not feel that their procedure is “tumescent” because the solution is not injected *beforehand* but part of the wand and procedure. The solution is injected *with* the water. Reviewing the liposuction/lipedema research (lipedema.org spreadsheet) I found the following references:

(1) US (Pena A, 2015) [Ultrasound]

(1) WAL (Stutz JJ et al, 2008) [Water-Assisted Liposuction]

(3) PAL (Sattler G et al, 2004) (Schmeller W et al, 2006) (Meier-Vollrath et al, 2004) [Power-Assisted Liposuction]

(3) All incl. laser (Pena A, 2015) (Serdev N, 2011) (Wollina U et al, 2014)

(1) LAL (Wollina U et al, 2014) (Laser Assisted Liposuction]

(10) Micro-Cannula (Rapprich S et al, 2012, 2010) (Jayashree, 2007) (Wollina U et al, 2019, 2017, 2015) (Schmeller W et al, 2011, 2006) (Meier-Vollrath et al, 2004) (Schneble N et al, 2016) [This is not a technique but rather a size, discussed below.]

**Bottom Line:** Understand that there are different techniques and cannula sizes but in terms of treating lipedema the operative terms are “lymph-sparing” and “tumescent.” I would also add “reconstructive” but that is not a technique but rather a distinction relevant to medical necessity and carrier reimbursement.

**Lymph-Sparing** is the specific surgical technique that is unique to removing lipedema fat. If not addressed a medical necessity review committee could determine that the procedure poses “a risk to the lymph system.” Therefore it’s a good idea to include it in the name of the procedure proposed. Any surgeon performing the procedure for lipedema should be trained in lymph-sparing liposuction. Some will argue that “there is no such thing” and others might argue that all tumescent liposuction is lymph-sparing. I would consider those minority opinions.

**Tumescent Liposuction** refers to the use of anesthesia during liposuction. The word “tumescent” means swollen and firm. By injecting a large volume of very dilute lidocaine (local anesthetic) and epinephrine (capillary constrictor) into subcutaneous fat, the targeted tissue becomes swollen and firm, or *tumescent*.

To my knowledge all lipedema fat removal uses a regional anesthetic either injected beforehand or injected *as part* of the liposuction (WAL) where the wand injects the water and anesthetic. Numerous plastic surgeons reference WAL on their website in reference to lipedema. If that is specifically *your* procedure and that’s how your surgeon documents the procedure, just be consistent.

The only downside I see would be the low probability that an insurance company would argue that only *WAL-specific* research applies to your situation. I do not think this would be an issue with the phrase: Lymph-Sparing Liposuction as that specifically addresses both unique aspects of liposuction for lipedema. The same argument would apply to PAL, LAL and ultrasound.

Below are definitions of different techniques/modalities:

**Tumescent Local Anesthesia (TLA):** is the anesthesia technique recommended for lymph sparing liposuction surgery. Therefor the phrase: Lymph-Sparing TLA would be appropriate and accurate for lipedema. It does not require a special or a specific type of wand.

**Micro-Cannula**: A liposuction cannula is a stainless steel tube which is inserted into subcutaneous fat through a small opening or incision in the skin. The outside diameter of micro-cannulas range from 1 mm to 3 mm. This does not address the techniques (listed below) but simply the diameter of the cannula).

**Water-Jet Assisted Liposuction (WAL™):** is the specific technique (wand) commonly used for patients who require lymph-sparing liposuction for lipedema. The lipedema fat is removed using a fan-shaped jet of water, which includes the anesthetic. BodyJet™ is a Water-Assisted Liposuction system.

**Power-Assisted Liposuction [PAL™]** is a specific type of liposuction (wand) that uses a vibrating motion; the procedure can be tumescent or not. PAL™ devices use power supplied by an electric motor or compressed air to produce either a rapid in-and-out movement or a spinning rotation of an attached liposuction cannula. Most research does not use the phrase “Power-Assisted Liposuction” or PAL™ but the phrase “vibrating cannula.”

**Laser-Assisted Liposuction (LAL) Smart Lipo™:** uses laser technology to coagulate and tighten the skin and boost collagen performance. This is listed as an option for lipedema on the [LipedemaProject.org](https://lipedemaproject.org/treatment-for-lipedema/) website.

Interesting side note: Dr. Amron, an expert in liposuction for lipedema, uses *all three techniques*: WAL, PAL and Smart Lipo as a three-step lipedema, fat-removal process. [[More Information Here](https://www.realself.com/question/dexter-smart-lipo-lipedema)].

**Ultrasonic-Assisted Liposuction** (UAL) (VASER® liposuction): requires the use of a large volume of tumescent fluid and uses either a metal probe or metal paddle to deliver ultrasonic energy and heat into subcutaneous fat. Marcia Byrd, MD uses this VASER® liposuction in addition to WAL and PAL [[More Here](https://lipedemaliposuctioncenter.com/vaser-liposuction/)].

**AirSculpt®:** This is a unique and patented procedure developed by Aaron Rollins, M.D., founder of Elite Body Sculpture and cosmetic specialist in Beverly Hills. According to the website it is “not considered liposuction.” It does not appear to be “tumescent.” But it *is* promoted as a treatment for lipedema. Without getting into the clinical efficacy argument, I think this could cause problems with both supportive research and with the CPT codes as it is not “suction assisted lipectomy.”

**CoolSculpting®** (aka Fat freezing or cryolipolis): is a non-surgical fat reduction procedure that freezes fat cells; it is an FDA-approved, non-invasive procedure that uses the power of cooling to disrupt fat cells underneath the dermis. This freezing energy crystallizes and eventually kills targeted fat cells without harming the surrounding healthy tissue. The body’s metabolic processes work to remove the dead fat cells, which lead to a noticeably slimmer treatment area. Coolsculpting™ is not recommended for those with Lymphedema or other conditions that affect the lymphatic system.

**Clinicians:** If you have any feedback, research or case studies concerning the above, please contact me at [lipoforlipedemareimbursement@gmail.com](mailto:lipoforlipedemareimbursement@gmail.com) or [ritecode@gmail.com](mailto:ritecode@gmail.com). It is important that any information in this document is accurate and clinically up-to-date.

## CPT™ Codes For Liposuction

**Question: I was told to submit the liposuction for lipedema procedure with CPT code 38999 (unlisted procedure, hemic or lymphatic system). Is that correct?**

I address this issue in the next section. Using an unlisted code adds another level of complexity toward obtaining reimbursement. Unlisted codes are rarely reimbursed.

There are currently (2020) four liposuction CPT™ codes. They have no Medicare RVU’s (there is no Medicare fee schedule for them):

|  |  |
| --- | --- |
| 15876 | Suction assisted lipectomy; head and neck |
| 15877 | Suction assisted lipectomy; trunk |
| 15878 | Suction assisted lipectomy; upper extremity |
| 15879 | Suction assisted lipectomy; lower extremity |

Technically these codes only describe Suction Assisted Lipectomy/Liposuction, sometimes abbreviated as SAL. There are numerous different types (techniques/modalities) of liposuction. However, the AMA CPT™ codes make no distinction between liposuction modalities or techniques (SAL, WAL, PAL, ultrasound, laster, etc…) I discuss [device types in more detail here](#_Types_of_Liposuction:).

An argument could be made that a new CPT™ code is necessary, not only for technique but the condition. Ideally, the new code would read: Lymph-Sparing Liposuction *for lipedema*. There is precedent in CPT™ codes in other fields for this:

92071: Fitting of contact lens for treatment of *ocular surface disease*

92072: Fitting of contact lens for management of *keratoconus,* initial fitting

The example above is particularly appropriate because a contact lens fitting linked to any *refraction diagnosis* is not a medical procedure and not reimbursed by any medical health insurance carrier. However, the two codes above are for a *therapeutic purpose* for a *specific medical condition* and *are* reimbursed by medical insurance carriers.

The introduction of the new term and recommendation for the unlisted code has created a new challenge it terms of which is the best way to submit a claim. Ultimately your Provider will decide what code is on the claim form. If you’ve made it this far I would show your surgeon the following information on Fibro-Lympho-Lipo-Aspiration (FLLA) and see if they are interested in reporting the procedure as an unlisted code.

If the carrier has a positive reimbursement policy referencing the existing CPT codes I would use them.

## Fibro-Lympho-Lipo-Aspiration (FLLA)

This is a bit technical so be forewarned. It is only for the very ambitious. Please share it with everyone you know. Submitting for a new CPT to the AMA is a multi-year, very involved process.

All the evidence and guidelines support that not only is **a modification of or derivation of suction lipectomy** the most effective treatment to relieve symptoms of and ameliorate disability caused by lipedema-modified suction lipectomy is **the only treatment of lipedema** shown to halt its progression. It goes by many names:

1. Tumescent Liposuction
2. Lymph-Sparing Liposuction
3. Lymph-Sparing, Tumescent Liposuction
4. Water-Assisted Liposuction (WAL)

It can also be referred to as **reconstructive/medically necessary liposuction** **for lipedema** (to differentiate it from cosmetic liposuction). That is more of a description related to reimbursement rather than a description of the actual procedure. However, currently the four CPT (suction-assisted lipectomy) codes do not address any of these details.

The proper description of the liposuction for lipedema modification is **Fibro-Lympho-Lipo-Aspiration (FLLA)**. The term is specifically referenced in the paper below:

18. Campisi CC, Ryan M, Boccardo F, Campisi C. **Fibro-Lipo-Lymph-Aspiration** With a Lymph Vessel Sparing Procedure to Treat Advanced Lymphedema After Multiple Lymphatic-Venous Anastomoses: The Complete Treatment Protocol. Ann Plast Surg. 2017;78(2):184-190. doi: 110.1097/SAP.0000000000000853.

**Everything** about the surgical suction application via cannula is different from standard suction lipectomy. The goal is to relieve symptoms, ameliorate disability, improve function and halt disease progression.

The technique is vastly different. Only small blunt cannulas are used, great care is used to not injure lymphatic which are already abnormal and increased risk of injury. Only the longitudinal orientation of cannulas is used at critical junctures. Preoperatively I scan and mark critical lymphatic structures. **The surgery averages 4-5 hours**, removed much larger aspirate volume than cosmetic suction lipectomy.

The benefit to lymphatics function comes not only from **the removal of subcutaneous adipose tissue,** but also the all components of the loose connective tissue including removing fibrosis in the interstitial space.

That is why **Fibro-Lympho-Lipo-Aspiration (FLLA) is the best description of the procedure**.

The term, *suction lipectomy*, suggests a technique whereby surgical insertion of cannulas into tissue attached to suction under tumescent anesthesia only removes subcutaneous fat for cosmetic improvements.

**Fibro-Lympho-Lipo-Aspiration** is directed at changing all components of the Loose Connective Tissue [ LCT]. For example, the application of suction-assisted cannulas has been shown to positively alter lymphatic function in patients with chronic lymphedema.13,15 Lymphatic stasis results in dermal fibrosis, deposition of proteoglycans and fibrosis in the matrix, and excess adipose tissue accumulation.16,17

Suction lipectomy for lymphedema, or more specifically, **Fibro-Lymph-Lipo-Aspiration**, has been shown to decrease limb volume in extremities with chronic lymphedema after the restoration of lymphatic flow with lymph node transplant or lympho-veno anastomosis through the removal of solid adipose and fibrotic material that is a result of lymphatic stasis.

FLLA on as a modification of suction lipectomy results in a sustained volume reduction of the limb, sustained improvement in lymphatic function and reduced risk of cellulitis in both lipedema and lymphedema.18

Again, **the goal of this surgery is not removal of fat.**

Fat may be an innocent bystander in the disease progression. The interstitial space, fibrosis and the subsequent development symptoms are the result of inflammation and increased extracellular fluid accumulation is what causes the symptoms and much of the disability.

**Suction lipectomy and its CPT 15879 is a completely inadequate code**.

Its description is completely inadequate for the procedure. Those carriers that reimburse for the procedure have valued the code at $1,412. There is no RBRVS valuation (no Medicare fee schedule) because it is considered a cosmetic code. (However there have been reports where Medicare did reimburse for the procedure [FatDisorders Youtube video; <https://www.youtube.com/watch?v=XDVRtgJlPnQ> ]

The skill, work involved and time assigned to this code by payers is not adequate. It best describes a cosmetic procedure in person close to ideal body weight, who has a "small pocket" of cosmetically unappealing fat removed to improve their shape.

When payers value lipectomy codes they assume at most a liter or slightly more of fat removed in an hour or less.

Prior to surgery, surgeons assess lymphatic landmarks, including peri-saphenous lymphatic collection pathways to plan to execute the surgery without their disruption. A great deal of skill is required to not injure lymphatics. **The surgery takes at least 4 hours and will often remove over 12 + Liters or 25 lbs of aspirate**. This is not just fat removed, but also proteoglycans and other extracellular matrix components.

Data supports the improvements in lymphatic function and symptoms that result from my surgery. All the data from the phlebologist / venous and lymphatic specialist in Germany like Rapprich and Schmeller show improvements in QOL and lymphatic function surrogates like the need for compression and compression pump use. So again, it is much more that fat removal.

**The free market valuation of lipedema surgery is from 7-30K for the procedure.**

Typical surgeon’s fees range from 7K (discounted) to 16K. The work involved in getting approval and payment from third-party payors for the surgery makes 16 K the number difficult to discount with 3rd party payers. Negotiating for single-payer agreements or contracted rates 10-12K makes sense.

New code requests must be submitted to the American Medical Association CPT committee by the professional associations and the individual surgeons; there also needs to be an advocacy effort regarding the need and purpose for the new procedure code.

This is process can take as long as five years. Often the AMA will introduce a category-three (CAT-III) CPT code (often called a “T” code because they end in a “T”) which is labeled as “investigational”, “experimental”, or temporary. Category III CPT codes have no RVU’s and are rarely paid. However I am aware of a few exceptions (based on extensive lobbying by interested parties). Therefore, until there was a new AMA CPT code, surgeons would need to report CPT code 38999: unlisted procedure, hemic or lymphatic system and in BOX 19 on the Claim Form list the code as: Fibro-Lympho-Lipo-Aspiration. Typically, you would then include a one or two page document outlining the procedure, it’s complexity, time and effort involved and appropriate reimbursement rate.

Clinical information and commentary above provided by Thomas Wright, MD in conjunction with Jeffrey Restuccio, CPC, COC, (certified coder, auditor and reimbursement specialist) Apr 27 2020.

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## How to use Research to Reverse Denials

You’re main weapon against the E/I/U argument is peer-reviewed research that proves the efficacy and need for liposuction for lipedema. My goal is to have a list of the very best research, sorted by robustness (ability to withstand peer-review critique) and keyword. There are hundreds of research studies concerning lipedema and over fifty regarding liposuction. But some won’t help your case.

The ones you use, particularly if you have access to a denial policy, should address the specific healthcare carrier concern. If the carrier states that “there is no evidence of long-term efficacy” then you need to produce long-term studies. If they reject a study because the “sample size” is too small then you need to produce studies with larger sample sizes.

There are hundreds of research studies regarding lipedema. There are over forty, peer-reviewed journal articles reviewing the benefits, efficacy, and safety of Lymph-Sparing Liposuction as the only surgical treatment for lipedema. We will be updating all of the information on the [website](http://www.lipoforlipedemareimbursement.com) often. Currently the best list of research papers and books is on the Lipedema Foundation Website below:

<https://www.lipedema.org/books-and-papers>

You can download an Excel spreadsheet of over 300 papers on lipedema (about 90 reference liposuction).

The latest publication at the time of this writing is very favorable toward Lymph-Sparing Liposuction: *Prevention of Progression of Lipedema With Liposuction Using Tumescent Local Anesthesia*: Results of an International Consensus Conference. It is a 2020 paper.

<https://www.ncbi.nlm.nih.gov/pubmed/31356433>

I would look at it first.

For a lay person it’s a daunting task knowing which research is considered the most scientifically sound. If you are unfamiliar with formal research studies, I would recommend either skipping this section or work with someone familiar with study designs and peer-reviewed research (Psychology majors are a good candidate and most have time on their hands [I can only say that because I *was* a Psychology major!])

(The website: [www.Lipoforlipedeareimbursement.com](http://www.Lipoforlipedeareimbursement.com) will be collecting, ranking and organizing research so you can use it. Below is strategic information on how to approach denials based on inadequate research.

Below is a list of the most common *design flaws* used by insurance companies and independent review boards (IRB’s) to deny a procedure as experimental investigational, or unproven and not medically necessary.

1. Small sample size.
2. Lack of comparison groups.
3. Limited follow up duration.
4. Variation in number of patients with data at each time point.
5. Substantial follow-up attrition.
6. Reduction in the utilization of inpatient hospital services for more invasive procedures not illustrated.
7. Reduced future services not illustrated.
8. Controversial or inconsistent outcomes.
9. Eliminated: studies with <21 patients
10. Eliminated: case reports, conference abstracts, editorial, notes, and comments.
11. The literature was not peer-reviewed, published evidence.
12. The precision, directness, and consistency of data did not support medical necessity (efficacy).
13. The applicability of the data to general practice was not established.

Concerning Independent Medical Review Boards there are pros and cons.Everyone is entitled to request an IRMB when appealing a medical insurance carrier denial.

“All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.”

–President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry [www.hcqualitycommission.gov].

However, if you look at the [Cigna liposuction for lipedema denial](#_Cigna_Denial_Policy) and the review by the IMRB, Hayes Inc. (FEB 2019) it is very critical of the available research and concludes that the procedure is Experimental / Investigational. The takeaway is that an IRMB may not help your case.

Each state may have specific rules concerning what is determined to be reconstructive versus cosmetic. For example, breast reconstruction surgery is protected by federal laws and cleft palate by state laws (in 15 states [[See Comparables Here](#_Comparable_Reconstructive_Procedure)]). Therefore, if you’re in a state that requires reimbursement for cleft palate paid as reconstructive, then it’s a *state law* and no longer a carrier option. Note that you must meet their strict documentation and risk guidelines. To my knowledge, at the time of this writing [AUG 2020], there are no state or federal guidelines concerning liposuction for lipedema. As a reimbursement strategy the legislative approach has merit.

The next document is an example of a good research paper with keywords to identify strengths.

## Lipedema: A Call to Action! (Buso G et al., 2019)

Authors: Giacomo Buso, Michele Depairon, Didier Tomson, Wassim Raffoul, Roberto Vettor and Lucia Mazzolai,

Wiley Online Library Obesity, 27, 10, (1567-1576), (2019).

**Below is an excerpt** of the most salient parts in regard to reimbursement for liposuction for lipedema. As always, I recommend you obtain [the original](https://onlinelibrary.wiley.com/doi/full/10.1002/oby.22597) for your records.

For patients with minimal or no improvement following conservative approaches, the following two surgical options may be considered: liposuction and lipectomy (**94**).

Notably, techniques employed in lipedema patients differ from those adopted for cosmetic purposes (**15, 66, 95**). Following introduction of Tumescent Local Anesthesia (TLA), super‐TLA, and vibrating cannulas, this risk has considerably decreased. Several investigations have shown that TLA is highly effective in terms of both cosmetic and functional outcomes.

**Schmeller et al.** (**15**) described an average reduction of 9,846 mL of subcutaneous fatty tissue after treatment, with an additional amelioration of sensitivity to pressure, edema, bruising, functional limitation, and cosmetic complaint (P < 0.001). Moreover, no serious complication occurred following the procedure, with wound infection rates of 1.4% and bleeding rates of 0.3% (**15**). Very recently**, Wollina et al**. (**97)** reported on 111 patients mostly with advanced lipedema treated by microcannular liposuction in tumescent anesthesia between 2007 and 2018. They described a median total amount of lipoaspirate of 4,700 mL, a median reduction of limb circumference of 6 cm, and a median pain level lowering from 7.8 to 2.2 at the end of treatment as well as improved mobility and bruising. Serious adverse events were observed in 1.2% of procedures, with infection and bleeding rates being 0% and 0.3%, respectively (**97**).

Unfortunately, lipedema surgical treatments are still too often not reimbursed by health insurance companies, thus representing an expensive option for the overwhelming majority of patients (**74**). In addition, despite several promising short‐term results, only a few studies have evaluated the long‐term efficacy of TLA for lipedema treatment (**15, 98, 99**).

**Total Research Papers** referenced are listed below: **Eight (8)** (15, 66, 74, 94, 95, 97, 98, 99)

15) (Schmeller W et al., 2012)

66) (Rapprich S et al., 2011)

74) (Halk AB et al., 2017)

94) (Warren AG et al., 2007)

95) (Stutz JJ, 2009)

97) (Wollina U et al., 2019)

98) (Baumgartner A et al., 2016)

99) (Peled AW et al., 2012)

**By Type**

Liposuction as surgical option (94)

Need for medical carrier reimbursement (74)

Long-Term efficacy Studies (15, 98, 99).

Tumescent Local Anesthesia (TLA), different than Cosmetic (15, 66, 95).

Highly effective outcomes (15) Improvement (97)

15. Schmeller W, Hueppe M, Meier‐Vollrath I. Tumescent liposuction in lipoedema yields good long‐term results. *Br J Dermatol* 2012; **166**: 161‐ 168.

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[Wiley Online Library](https://onlinelibrary.wiley.com/doi/10.1111/bjd.14289) [CAS](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=32&doi=10.1002%2Foby.22597&key=1%3ASTN%3A280%3ADC%252BC28vitlCnsw%253D%253D) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=26574236) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000376480700102)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=174&publication_year=2016&pages=1061-1067&journal=Br+J+Dermatol&author=A+Baumgartner&author=M+Hueppe&author=W+Schmeller&title=Long%E2%80%90term+benefit+of+liposuction+in+patients+with+lipoedema%3A+a+follow%E2%80%90up+study+after+an+average+of+4+and+8+years)

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[Crossref](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=16&doi=10.1002%2Foby.22597&key=10.1097%2FSAP.0b013e318215791e) [CAS](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=32&doi=10.1002%2Foby.22597&key=1%3ACAS%3A528%3ADC%252BC38Xis1Ont7k%253D) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=21629090) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000300776500017)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=68&publication_year=2012&pages=303-307&journal=Ann+Plast+Surg&author=AW+Peled&author=SA+Slavin&author=H+Brorson&title=Long%E2%80%90term+outcome+after+surgical+treatment+of+lipedema)

## CoMorbidities List / Threats to Life

A carrier will deny your claim if the patient is too sick for the procedure and their concerns are not addressed. This type of denial is different than a determination that the procedure is cosmetic, experimental, investigational, or unproven. The carrier may reject the claim as “not medically necessary” but it’s due to the *threat to the patient*, not the efficacy or value of the procedure. The most important co-morbidities to address are vascular issues, morbid obesity, and the patient’s age.

**Comorbidities** and any threats to the patient must be addressed in the pre-authorization documentation; address how you will reduce any risk of injury (death) to the patient and that they are healthy enough for the procedure. Other pre-existing conditions may preclude the liposuction (see Kaiser Permanente 2014 CA denial and appeal).

**Common comorbidities** associated with a primary lipedema condition:

1. Chronic Pain
2. Diabetes mellitus and Metabolic syndrome
3. Phlebitis (DVTs). Deep-Vein-Thrombosis is a common co-morbidity that must be addressed particularly in the more severe stages.
4. Easy bruising often from no apparent cause or injury
5. Arthritis of all kinds, especially Osteoarthritis in hips, knees, and hands, but Rheumatoid Arthrosis is common also.
6. Medium-Chain Acyl-Coa Dehydrogenase deficiency (MCAD). A rare genetic condition where a person has problems breaking down fat to use as an energy source.
7. Hypermobility
8. Lymphedema (usually secondary) and angioedema (the latter comes with MCAD triggering usually)
9. Celiac disease and all forms of gluten sensitivity (accompanying malabsorption and malnutrition and nutritional deficiencies despite diet and even supplementation sometimes.)
10. Sleep apnea, both obstructive airway issues and Central Nervous System (CNS) Apnea (neurologic in origin requiring a sort of breathing “pace maker”)
11. Sciatica
12. Food and drug allergies and sensitivities with a lot of paradoxic and unexpected super sensitive reactions
13. Chondromalacia (cartilage loss) of all kinds, especially patellae (loss of cartilage in the knees, but can occur elsewhere, e.g. hips)
14. Chronically low Vitamin D levels
15. Common Variable Immune Deficiency (CVID) of all kinds leaving us prone to frequent & worsening recurrent infections of all kinds, especially respiratory & UTI’s
16. Dercum’s disease (looks like Lipedema plus MCAD). It causes fatty lipomas.
17. Dysautonomia of all kinds, most notably poor temperature and BP regulation (high or low, see POTS below)
18. Electrolyte imbalances (often low potassium)
19. GastroEsophageal Reflux Disease (GERD) (weak hiatal sphincters and MCAD can contribute here – the stomach produces acid in response to histamine from food reactions).
20. Hiatal hernia (stomach to esophagus sphincter) and all other forms of hernias just about anywhere (inguinal, duodenal, abdominal, etc…)
21. Irritable Bowel Syndrome (IBS) & proclivity toward constipation, but with quick flips to diarrhea (likely food allergies/MCAD).
22. Kidney trouble (stones).
23. Leaky gut syndrome.
24. Low Magnesium levels.
25. Low Selenium levels.
26. Low Vitamin and Mineral Levels
27. POTS (Postural Orthostatic Tachycardia Syndrome) – a subset of dysautonomia involving BP drops and syncope (fainting).
28. Restless Leg Syndrome (RLS) and leg cramps (often eased by increased magnesium).
29. Skin tears or rips, trouble suturing, would dehiscence (trouble healing post-surgery, especially soft inner tissues).
30. Tendonitis and bursitis of all kinds (aka “soft tissue rheumatism”, alt. tendinitis).
31. Varicose and spider veins, often early onset, easy bruising and bleeding from same.
32. Mood disorders, especially anxiety and depression.
33. Auto-immune diseases
34. Thyroid issues (high and low, often auto-immune despite normal TSH “levels”)
35. Multiple Sclerosis

## Experimental/Investigational/Unproven Policies Short Version

Ten healthcare carriers; evaluated March 12 2020. This is a summary. The more detailed, 8-page document is [continued in the Appendix.](#_Experimental/Investigational/Unprov)

Below I reviewe ten Experimental/Investigational/Unproven (E/I/U) healthcare policies. While very similar, there are subtle differences in the definitions, requirements, and restrictions. I have **emphasized** issues and terms I consider important. Remember:

* *Words* matter
* *Specificity* matters
* *Dates* matter
* *Accuracy* matters

Tailoring your packet, documentation, and letters to the carrier’s policy requirements and *verbiage* is the very best strategy to obtain pre-authorization and win an appeal if denied.

**Experimental / Investigational / Unproven Policies**

|  |  |  |
| --- | --- | --- |
| 1 | Anthem Blue Cross Blue Shield (lipo for lipedema approved) | 11/1/2019 |
| 2 | Allways health insurance (lipo for lipedema specifically excluded) | 3/1/2020 |
| 3 | BCBS-ND (lipo for lipedema not referenced) | Jan 1 2020 |
| 4 | BCBS-VT (lipo for lipedema not referenced) | 5/1/2018 |
| 5 | Fallon Health (lipo for lipedema not referenced) | 9/1/2019 |
| 6 | HealthNet (lipo for lipedema not referenced) | 1/1/2020 |
| 7 | Meridian Health Plan (lipo for lipedema not referenced) | 11/1/2015 |
| 8 | Molina Healthcare (lipo for lipedema not referenced) | 6/25/2014 |
| 9 | Ventura County Health Plan (lipo for lipedema not referenced) | 2/14/2019 |
| 10 | Wellmark-BC-BS (lipo for lipedema not referenced) | 2/6/2020 |

Below is a list of specific *terms* and *phrases* that you can cut-and-paste into your pre-authorization or appeal documentation packages.

## Cut and Paste Phrase List

**Below is a list of terms, phrasing and supporting research** you can include in your pre-authorization or appeal documentation package as appropriate:

Medically effective

FDA-approved equipment

Conclusions...the effect of the intervention on health outcomes

Make argument …that measurement(s) or alteration affects health outcomes

Safe or effective

Exceeding the outcome of alternative therapies

Improve health outcomes

Results are applicable outside the research setting

The specific diagnosis of lipedema warrants approval.

Well-designed research

Well-conducted investigations

Nationally-recognized medical journals

Published in peer-reviewed journals

Quality of the body of studies and the consistency of the results

Superior clinical outcomes [Fallon health; use of "superior"]

Greater safety or efficacy than conventional treatments

Technological assessments

Randomized control studies

Published peer-literature

Expert opinions

Recognized by the plan as standard medical care for the disease being treated

Proven beneficial impact

Go to the [website](http://www.lipoforlipedemareimbursement.com) for the .doc version

## Lipedema Signs and Symptoms Checklist

This list is available in PDF format from several websites: [Lipedema Canada](http://lipedemanetworkcanada.com/wp-content/uploads/2015/11/Lipedema-Checklist.pdf), [Lipocura Germany](https://lipocura.de/wp-content/uploads/2017/08/Lipoedema_Checklist-signs-and-symtoms_Lipocura.pdf); It is for informational purposes only; please discuss all clinical issues with your doctor.

Lipedema is a symmetrical increase in fat, usually occurring on the legs, buttocks, and the arms, and generally affects only women. The fat distribution in the body is disturbed because of this disease and not, as assumed, a consequence of overweight. In addition to fluid retention, massive pressure pain occurs, which in many cases is associated with increased bruising and pressure pain in the affected area. The leg becomes evenly thick and heavy, usually from hip to ankle. The lipedema can also manifest in the upper arms, while the upper body, hands and feet of the patient usually remain slender.

If you think you may have lipedema please complete this checklist with symptoms.

☐ Weight is gained disproportionately on hips, thighs and below knee (usually bilateral - affects both sides - and symmetrical - occurs evenly)

☐ Larger bottom half and smaller waist

☐ The feeling of fatty ‘nodules’ underneath the skin

☐ Bruising occurs easily and is often unexplained

☐ Legs are very sensitive to the touch

☐ Deep throbbing/achy pain in legs

☐ Pain in knee joints

☐ Legs feel heavy and swell throughout the day (especially after long periods of standing or sitting) but resolve overnight

☐ Fat on legs is soft and looks dimpled like “orange peel skin“, legs may feel cold to the touch

☐ Lipedema fat does not respond to dieting

☐ Hands and feet are not affected

☐ Skin of affected areas may be pale and cold

☐ Upper arms may also be disproportionately fatter

☐ Increased swelling in hot weather

If you can answer in the affirmative more than 7 points you may have lipedema.

## Comparable Reconstructive Procedures denied as Cosmetic

This is included more as a thought-experiment. I don’t know if the “comparable procedure” argument would have any weight with an appeal review committee concerning reimbursement for liposuction for lipedema. I’ve not tried this strategy yet. However, if you’re working on your second or third-level appeal, it might be worth it to add this to your argument. If you use it and it works please let me know!

The bottom line is that lipedema has as at least as much, and it could be argued *more* of an impact on the patient’s function, gait, mobility, and Quality of Life as other procedures that the carrier currently reimburses as reconstructive. I have listed several below. The goal here is *not* to diminish the impact of breast reconstruction or cleft palate repair, but to add liposuction for lipedema as a comparable procedure for an *equally debilitating* condition.

It has taken many years for other procedures to be accepted as reconstructive and not cosmetic. Changes in legislature are the result of advocacy and lobbying by many groups. Liposuction has a long way to go until it’s widely accepted as reconstructive for lipedema. Most of the public and many Providers are not even aware that lipedema is a separate condition from obesity. Many consider liposuction only cosmetic. This education process will take years.

**Reconstructive Liposuction**: Care should be taken to refer to liposuction for lipedema as ***reconstructive*** and never ***cosmetic***.

**Comparable Treatments now considered reconstructive [AUG 2020]**

**Medicare Part B Breast prostheses reimbursement:** Medicare Part B (Medical Insurance) covers some external breast prostheses (including a post-surgical bra) after a mastectomy. Part A covers surgically implanted breast prostheses after a mastectomy if the surgery takes place in an inpatient setting. Part B covers the surgery if it takes place in an outpatient setting. The patient pays 20% of the Medicare-approved amount for the doctor's services and the external breast prostheses. The Part B deductible applies.

Medicare reimburses for:

1. Breast prosthesis: national law
2. Panniculectomy
3. Bariatric surgery
4. Upper-eyelid surgery ([blepharoplasty] blocks vision) versus lower-eyelid lid surgery (considered cosmetic).
5. Cleft lip repair: 15 states require this a reconstructive

**Cleft Lip Repair:** State law requires reimbursement in 15 states for cleft lip repair as reconstructive.

**Liposuction** as an adjunct to Abdominoplasty and Panniculetomy (Tummy Tuck):

**Aetna Cosmetic Surgery Policy [CPB-0031]:** liposuction when performed with a panniculectomy and also liposuction when performed with breast reconstruction after a mastectomy and not lipedema is considered **reconstructive** and not cosmetic. Update due 1-9-2020.

Documentation must demonstrate to the medical insurance company the patient has completed conservative non-surgical treatment of lipedema without adequate relief of their lipedema symptoms..

## Summary

Toward my goal of increasing reimbursement for liposuction for lipedema by medical healthcare insurance companies I established the following objectives:

1. Contact Providers, researchers, patients, associations, and insurance companies (and explain our mission).
2. Gather information and research. Organize it.
3. Disseminate accurate and up-to-date information (related to reimbursement).
4. Educate all of the above.
5. Provide a specific deliverable: The Reimbursement Guidebook–the information in an editable format.

This document and additional information is available on the [website f](http://www.lipoforlipedemareimbursement.com/)or free.

If you are a patient or work in a surgeon’s office that has little experience with filing claims, documentation requirements to establish medical necessity, and working complex appeals, you might want to look into my general coding and billing manual: *The Ultimate Compendium of Coding, Billing, and Documentation Advice For Primary Care (2020 Edition) available on my* [*www.ritecode.com*](http://www.ritecode.com) *website.*

Yes, the focus is Primary Care but most all of it applies to all specialties. With 100 key coding and billing concepts at about a page each it is a great real-world introduction to the complex world of coding, billing, compliance, documentation and reimbursement. If you are new to reimbursement and decide you like coding and billing, I’ve been training coders and billers since 1996. Everything relating to the reconstructive versus cosmetic argument is in this document.

## Author Biography

Jeffrey Restuccio, CPC, COC, MBA is a resident of Memphis, TN since 1980. He has two coding certifications: the Academy of Professional Coders (AAPC) certified professional coder for physician (outpatient) reimbursement and the AAPC certified professional coder for hospital (inpatient) reimbursement. Jeff has been a certified coder since 1999.

Jeff has the unique combination of over twenty years of experience, medical coding certification (CPC & COC), training experience (medical coding and billing), a strong background in databases and Information Systems, and an MBA in Finance.

Jeff is an experienced healthcare educator and auditor, having conducted over 365 live training courses, worldwide on CPT and ICD-10 coding and billing since 2007. He has personally audited over 10,000 medical records. Over his career he has instructed thousands of doctors, coders and billers through his online training courses and reimbursement manuals available on [www.ritecode.com](file:///C:\Users\Ritecode\Dropbox\0%200%200%200%202020%20BUSINESS\Proposals\Microaire\Website\Kindle%20Book\www.ritecode.com).

Jeff has assisted several companies with unique requests including new HCPCS code submission, preparing white papers outlining the reimbursement landscape and the submission process as well as the many reimbursement hurdles with new codes and technology.

He consulted with a national children’s hospital in Memphis TN, full-time for over 18 months. I trained their coding staff, assisted in converting from an outside to an inside billing system. He created and implemented a *carrier-specific* rules database for over 350 insurance carriers by carrier and CPT™ code.

Jeff has taught coding and revenue cycle *internationally* (United Arab Emirates) working with Providers and staff to learn CPT™ concepts and documentation standards.

Jeff has also worked with reimbursement database startup companies teaching reimbursement concepts to management and the programming staff. This included all revenue cycle sites of services: office (professional fees), outpatient, ASC, HOPD, and inpatient hospital.

He has worked with numerous vendors (Alcon, Abbot, Pfizer, Microaire), software companies (Eli Global) and state medical (optometry) associations (CA and NE). Jeff has taught coding, billing, and compliance seminars at several universities (Ketchum [CA], New England School of Optometry, and Nova College of Optometry).

Jeff has a BA from West Virginia University and an MBA from the University of Memphis.

# Appendix

These are continuation documents (experimental and Investigational) or pending documents. I include them to solicit help from readers. I will be updating them periodically and my goal is to include them in the main document later this month [AUG 2020].

## Experimental/Investigational/Unproven Policies Long Version

Ten healthcare carriers; evaluated March 5 2020.

Below I reviewed ten Experimental/Investigational (E/I) healthcare policies. The goal here is to compare and contrast them. While very similar, there are differences in the definitions, requirements, and restrictions. I have **emphasized** issues and terms I consider important. Remember my mottos:

* *Words* matter
* *Specificity* matters
* *Dates* matter
* *Accuracy* matters

Tailoring your pre-authorization packet, documentation, and letters to the carrier’s policy requirements and *verbiage* is the very best strategy to obtain pre-authorization and win an appeal if denied. At the end of this document is a cut-and-paste list of key phrases to include in your pre-authorization and appeal documents.

**Experimental / Investigational / Unproven Policies**

|  |  |  |
| --- | --- | --- |
| 1 | Anthem Blue Cross Blue Shield (lipo for lipedema approved) | 11/1/2019 |
| 2 | Allways health insurance (lipo for lipedema specifically excluded) | 3/1/2020 |
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| 4 | BCBS-VT (lipo for lipedema not referenced) | 5/1/2018 |
| 5 | Fallon Health (lipo for lipedema not referenced) | 9/1/2019 |
| 6 | HealthNet (lipo for lipedema not referenced) | 1/1/2020 |
| 7 | Meridian Health Plan (lipo for lipedema not referenced) | 11/1/2015 |
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**Anthem Blue Cross Blue Shield** has a published E/I policy (2015) and a more current policy NC00009, *Cosmetic and Reconstructive Services* accepting liposuction for lipedema as reconstructive and medically necessary. It was effective 11/1/2019.

All policy decisions are at the discretion of the medical director.

The Anthem policy from 2015 (outdated) includes a list of E/I **research quality and efficacy flaws**.

**\*\*\***

**Allways Health Insurance** provides coverage when the surgery or procedure is reconstructive in nature, i.e. needed to improve the functioning of a body part, treat an associated medical complication, or is otherwise medically necessary, even if the surgery or procedure may also improve or change the appearance of a portion of the body. Policy Date: 3/1/2020.

Note: InterQual® Criteria Lookup link [used to determine if panniculectomy is warranted.]

Note: Liposuction is often an integral part the surgical removal of excessive skin [panniculectomy ]; this is not separately reimbursed.

[Excluded are] Any procedure where the primary purpose is to **enhance aesthetics**, including but not limited to: …**liposuction.**

**General Exclusion**: 4. **Liposuction for lipedema** [this is specifically excluded].

March 2020: Annual review. *Added exclusion Liposuction for lipedema*. References updated.

**\*\*\***

**BCBS-ND** Experimental / Investigational Revised Jan 1 2020

Experimental/Investigational services are defined as a treatment, procedure, facility, equipment, drug, service or supply (“intervention”) that has been determined not to be **medically effective** for the condition being treated.

Charges submitted for the services listed in this policy are denied as experimental / investigational. The determination for denial is based on ANY of the following reasons:

1. The intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s).
2. Available scientific evidence does not permit **conclusions c**oncerning **the effect of the intervention on health outcomes.**
3. The intervention is not proven to be as **safe or effective** in achieving an outcome equal to or **exceeding the outcome of alternative therapies.**
4. The intervention does not improve health outcomes.

The intervention is not proven to be **applicable** **outside the research setting**. [Not applicable to the general population; find research supporting this].

The policy includes a long list of CPT™ codes but the liposuction CPT™ codes were not listed.

**\*\*\***

**BCBS-VT** Experimental / Investigational; makes point that the **diagnosis code** will cause the denial. Policy Date: 5/1/2018.

“Experimental of Investigational Services” means health care items or services that are either **not generally accepted** by informed health care providers **in the United States** [perhaps omitting foreign research common in lipedema? - Jeff] as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.

The evidence should consist of **well-designed** and **well-conducted investigations** published in **peer-reviewed** journals. The **quality** of the body of studies and the **consistency** of the results are considered in evaluating the evidence.

The evidence should demonstrate that the technology can **measure** or **alter the physiological changes** related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

The BCBS-VT policy is 87 pages and a pretty good overview; it is mostly a long list of complete CPT codes**. Liposuction not addressed** or found in the E/I/U policy document.

\*\*\*

**Fallon Health** excludes coverage of experimental/investigational procedures due to their lack of reliable or detailed clinical evidence of **superior clinical outcomes**. Fallon Health evaluates many different types of clinical evidence in determining if a procedure or treatment has a **greater safety or efficacy** **than conventional treatments**. This is inclusive but not limited to published technological assessments, randomized control studies, published peer literature, and expert opinions.

Fallon Health will evaluate available, peer-reviewed scientific literature in relation to an overall clinical outcome and it’s acceptance of use in a clinical setting. **Prior authorization is required** for the use of any service or procedure as outlined in this policy. These requests must be supported by the treating provider(s) medical records. Policy Date: 9/1/2019.

In your appeal, **reference experts in the field of lipedema and liposuction**.

I would first look at the FEB 2020 liposuction for lipedema outcomes research paper and the list of researchers. There is no reference to liposuction or lipedema for their liposuction or their CPT codes in the policy.

\*\*\*

**HealthNet** E/I/U Policy 1/1/2020; some Medicaid policies.

Health Net considers as Experimental or Investigational if it meets any of the following:

1. It is **currently the subject of active and credible evaluation** (e.g., clinical trials or research) to determine: clinical efficacy, therapeutic value or beneficial effects on health outcomes, or benefits beyond any established medical based alternative. [this verbiage suggests to me that they could deny any procedure currently being evaluated - Jeff]
2. Does not have FDA approval.
3. The most recent peer-reviewed scientific studies published or accepted for publication by **nationally recognized medical journals** do not conclude, or are inconclusive in finding, that the Service is **safe and effective** for the treatment if the condition for which authorization of the Service is requested. safe / effective

Liposuction is not addressed or found in the policy document.

\*\*\*

**Meridian Health Plan**

E/I/U is any procedure, device or pharmaceutical agent that is **still undergoing pre-clinical or clinical evaluation [could deny anything - Jeff]**, and/or has not yet received regulatory approval. It is the use of a service, procedure or supply that is not recognized by the Plan as **standard medical care** for the condition, disease, illness or injury being treated. A service, procedure or supply includes but is not limited to the diagnostic service, treatment, facility, equipment, drug or device. When basic safety and efficacy have been demonstrated by the experimental scientific process, the investigational phase begins. Policy Date: 11/1/2015

Adequate evidence is defined as at **least two documents** of medical and scientific evidence that indicate that the proposed treatment is likely to be beneficial to the member adequate evidence

The Meridian Health Plan is particularly detailed. I copied it to a separate word document.

\*\*\*

**Molina Healthcare Experimental / Investigational Policy:** no reference to any specific CPT codes or procedures; Policy Date: 6/25/2014 (outdated)

“Excluded…are procedures…that have not successfully completed a Phase III trial“

Molina Healthcare Molina Healthcare defines the terms “experimental” or “investigational” or “unproven” (E/I/U) as the use of a technology drug, device, treatment or procedure that has not been recognized as having **proven benefit** in clinical medicine for any condition, illness, disease or injury being treated

Molina Healthcare has **five criteria**:

1. FDA approval
2. Published peer-reviewed literature must demonstrate the **proven beneficial impact** of the service/procedure on health outcomes for the given indication.
3. Published **peer-reviewed literature** must demonstrate that the technology must be at least as effective as established technology for the given indication.
4. Published peer-reviewed literature must demonstrate evidence that the technology improves health outcomes over time for the given indication.
5. The outcomes for the given indication must be obtainable outside investigational settings within the medical community.

\*\*\*

**United Healthcare/Oxford Health Experimental / Investigational Policy**

This is for *Medicare coverage of clinical trials*; Policy Date: 1/1/2018

Remember that federal or state mandates trump carrier policies. Individual plans vary. Oxford has plans in different states.

Oxford recognizes that **peer-reviewed** documents in scientific and medical literature may establish that an experimental and/or investigational treatment or procedure **may be better than** the standard treatments available to treat a member’s life threatening or disabling condition and/or disease. [Way this reads is more lenient than others; more leeway to appeal and argue your case - Jeff].

Oxford has determined that it will create a limited exception to the exclusion of experimental and investigational treatments and provide coverage for in-network experimental and investigational procedures that meet the criteria set forth in this policy. Such coverage is subject to the member’s other benefits and exclusions. Oxford’s determination of whether the criteria have been met will be based upon the opinion of an independent consultant/peer reviewer with expertise in the area of practice appropriate to treat the member’s condition or disease.

Exception: For New York Plans, the member's condition and/or disease is not required to be life threatening or disabling.

United Healthcare/Oxford Health Under no circumstances will this policy extend coverage to **unproven therapies**. [United Healthcare is the only carrier I’ve found so far that provides a separate definition of “unproven.” - Jeff]

**Unproven therapies** are treatments or procedures that lack significant medical documentation to support their medical effectiveness. Oxford does not provide coverage for any treatment modality that has not been proven medically effective or is not generally recognized as effective or appropriate for the particular diagnosis or treatment of the member’s particular condition.

Documentation Requirements: The member’s **medical record**, in conjunction with at least **two (2) published peer-reviewed documents** from the available scientific and medical evidence and any other pertinent information supplied, must establish that the proposed experimental or investigational treatment is likely to be more beneficial that any standard treatment(s) for the member’s life-threatening or disabling condition or disease.\*

The UH policy is long and very detailed; recommend reading for the ambitious.

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**Ventura County Health Plan Experimental / Investigational** Policy Date: 2/14/2019

Approval for E/I/U procedures must be consistent with §1370.4 of the Knox Keene Act, experimental or investigational procedures:

Life-threatening condition; standard treatment unsuccessful, ineffective and proposed treatment likely to be effective; treatment is "promising."

A **promising treatment** is one that has shown effectiveness as supported in credible peer reviewed literature or by the credible medical opinion of independent medical experts in the relevant specialty, designated by VCHCP. [First instance of “promising treatment” defined - Jeff]

This policy outlines how to get an **E/I/U treatment approved**; it is not how to avoid the designation, it is how to **get an exception** to a procedure that is listed as not covered..

\*\*\*

**Wellmark BC-BS** is in Iowa and South Dakota. It is dominant in Iowa. It is an independent licensee.

The terms "unproven, experimental or investigational" are generically defined as: A supply, procedure, therapy or device whose **effectiveness has not been demonstrated** by required scientific evidence and properly authorized by governing entities in order to be acknowledged as medically effective for the improvement of function for specific conditions or treatment. Policy Date: 2/6/2020

A treatment is considered investigational or experimental when it has progressed to limited human application, but has not **achieved recognition** as being **proven effective** in clinical medicine. 2/6/2020

To determine investigational or experimental status, we may refer to the technical criteria established by the Blue Cross and Blue Shield Association, including whether a service, supply, device, or drug meets these criteria:

It has final approval from the appropriate governmental regulatory bodies. FDA approved

1. The scientific evidence must permit conclusions concerning its effect on health outcomes. conclusions are overwhelming and consistent
2. It improves the net health outcome. focus on net health outcomes
3. It’s as beneficial as any established alternatives. no other alternatives
4. The health improvement is attainable outside the investigational setting. outside setting

**General E/I/U Information**

The national Blue Cross and Blue Shield Association has a Medical Advisory Panel responsible for setting policy on what is Experimental / Investigational / Unproven.

State boards also weigh in on what is considered experimental, investigational, unproven or allowed. A good example from Eyecare is that optometrists are specific set of procedures but it varies by state Optometry board.

Use **quantitative scores** whenever possible (e.g., decrease of pain, increase of mobility, six minute walk evaluation, risk of fall).

Some carriers define **defect** as: pain or other physical deficit that interferes with activities of daily living or impaired physical activity.

## Expert Opinion Letter Template

**Hold Harmless Statement**

This expert opinion for liposuction for lipedema reimbursement is provided for educational purposes only. It is not intended to represent the only, or necessarily the best, documentation or advice for the situations discussed, but rather represents an approach, view, statement, or opinion that may be helpful to persons responsible for writing an expert opinion letter in a medical clinic.

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## Cigna Denial Policy of liposuction for lipedema (2019)

I’ve formatted the original policy for readability and emphasis. Please refer to the original document [Jeff]. The purpose of this document is to provide insight how and why a medical healthcare carrier will *deny* your pre-authorization or appeal. It is a little technical but read it carefully, work with a friend, and don’t feel bad if you have to put it away for a few days and read it all over again. Take notes, make index cards, reduce any distractions and read the entire Reimbursement Guidebook. I have spent over 250 hours creating it; to save well over ten-thousand dollars it should be worth it to you to spend at least a tenth of that time.

1. **Literature Review:** There is a paucity of evidence in the peer-reviewed literature addressing liposuction for the treatment of lipedema.
2. Studies are mainly **case series** with no comparator group.
3. There is a lack of **consistent criteria** to determine **the ideal time** or **patient characteristics** for liposuction in the treatment of lipedema.

A **February 2019 Hayes Evidence Analysis Research Brief** on liposuction for the treatment of lipedema concluded that:

“There is insufficient published evidence to assess the safety and/or impact on health outcomes or patient management for the use of liposuction for the treatment of lipedema”.

The available published literature addressing liposuction for the treatment of lipedema is sparse and of low quality.

A search of the peer-reviewed literature yielded a paucity of research reporting outcomes in patients treated with liposuction for lipedema.

A total of 13 abstracts were retrieved, including one pretest/posttest study (Wollina, et al., 2019, n=111)

**Five survey studies** (Baumgartner et al.

1. [2016], n=85; Rapprich et al.
2. [2015], n=85; Dadras et al.
3. [2014], n=25; Rapprich et al.
4. [2011], n=25; Schmeller et al.
5. [2012], n=112) with potential overlapping patient groups,

Three systematic review articles (Halk et al.

1. [2017]; Reich-Schupke et al.
2. [2017] and Forner-Cordero et al.
3. [2012]), one case series (Wollina et al. [2014], n=3)

Three review articles:

1. (Wollina [2018]
2. Bellini et al. , [2017]
3. Okhovat et al.[2015]).

The takeaway here is the studies above were not considered persuasive by Cigna (and Hayes Research) to consider liposuction for lipedema medically necessary and reconstructive and reimbursable. Note that that no research from 2019 or 2020 is included.

In a case series study, Wollina, et al., (2019) analyzed 111 patients with lipedema not responding to complex decongestive Therapy (CDT).

The patients underwent a total of 334 liposuctions.

Comorbidities were recorded.

The study included patients with a diagnosis of lipedema.

All were females aged 20–81 years of age (median ± standard deviation: 44 ± 16.8 years).

They had been treated by CDT for at least six months without improvement or experienced deterioration of pain sensations and/or leg volume.

The study included seven patients with lipedema Stage I, 50 patients with Stage II, and 48 patients with Stage III.

All patients had an involvement of the legs including 108 patients with a dominance of the upper legs and two with a more pronounced involvement of the lower legs.

Twenty-seven patients also had an involvement of the arms (24%).

The delay of diagnosis was between 1 and 21 years.

Eighty percent of patients had at least one comorbidity (e.g., obesity, lymphedema, and diabetes).

The intervention was micro-cannular liposuction in tumescent anesthesia (TA) with the classical mechanical liposuction, some patients had a 980 nm-diode laser-assisted liposuction.

The primary outcomes were reduction of limb circumferences, pain (on a 10-point visual analogue scale [VAS]), bruising, improvement of mobility and adverse events.

The median follow up was 2.0 ± 2.1 years.

A follow up between five and seven years was available in 18 patients.

The median total amount of lipoaspirate was 4,700 ml, with a range of 950–14,250 ml.

The median reduction of limb circumference was 6 cm.

The median pain level before treatment was 7. 8 and 2. 2 at the end of the treatment.

An improvement of mobility could be achieved in all patients and bruising was reduced.

None of these patients had a relapse of lipedema.

Serious adverse events were observed in 1.

2% of procedures, the infection rate was 0% and the bleeding rate was 0. 3%. In 4.5% of patients with most advanced disease, other surgical procedures had been performed after completion of liposuction, such as thigh or arm lift, laser lipolysis, or debulking surgery to obtain best results.

**Limitations of this study** include the lack of a comparator group, small patient population and loss of patients to long-term follow-up.

In a case series study**, Schmeller et al.(2006)** reported the efficacy and safety of surgery (liposuction) concerning appearance and associated complaints.

Twenty-eight patients, who had undergone conservative therapy over a period of years, were treated by liposuction under tumescent local anesthesia with vibrating microcannulas.

Twenty-one could be reevaluated after an average of 12.

2 (1–26) months.

From 28 patients, 15 were operated on once, eight twice, two three times, and three four times.

The average amount of fat removed per session was 3017 mL, with a range of 1060 to 5500 mL depending on the size and number of operated areas.

The authors reported that all patients showed improvement, with normalization of body proportions.

Spontaneous pain, sensitivity to pressure, and bruising either disappeared completely or improved.

Other than minor swelling for a few days, no complications could be observed following surgery.

All patients reported an increase in their quality of life.

Physical therapy had to be continued to a much lower degree.

**Limitations of the study** include the lack of a comparator group, small sample size and short-term follow-up.

**Forner-Cordero 2012** reported in a systematic review of the literature that there is a lack of knowledge and little evidence about lipedema, especially among obesity experts.

Treatment protocols are stated to be comprised of conservative (decongestive lymphatic therapy) and surgical (liposuction) approaches.

The authors concluded that current knowledge about lipedema as a hidden epidemic is scarce, but the scientific interest is increasing.

More studies are required to know the real prevalence and to reach an earlier diagnosis of this disorder.

Diagnosis and treatment should be made as early as possible to prevent complications associated with increased functional and cosmetic morbidity.

**Professional Societies/Organizations**

No evidence-based clinical practice guidelines were located for lipedema.

**Centers for Medicare & Medicaid Services (CMS)**

• National Coverage Determinations (NCDs): No NCDs found.

• Local Coverage Determinations (LCDs): No LCDs found.

**Liposuction for Lipedema Use Outside of the US**

In June 2019, the Canadian Agency for Drug and Technologies in Health (CADTH) published a *Rapid Response Report: Summary with Critical Appraisal on Liposuction for the Treatment of Lipedema-A Review of Clinical Effectiveness and Guidelines.*

The key research questions were: what is the clinical effectiveness of liposuction for the treatment of lipedema and what are the evidence-based guidelines regarding the use of liposuction for the treatment of lipedema? The authors’ conclusions state that “information about the clinical effectiveness of liposuction for the treatment of lipedema was sourced from five uncontrolled before-and-after studies:”

Dadras, et al., 2017

Wollina, et al., 2019

Schmeller, et al., 2012

Rapprich, et al., 2011

Baumgartner, et al., 2016

Data from the studies indicated that in patients with lipedema, treatment with liposuction resulted in a significant improvement of pain, sensitivity to pressure, edema, bruising, feeling of tension, and quality of life.

The patients also experienced significant reductions in size extremities and restriction of movement, and the need for conservative therapy for lipedema.

The benefits of liposuction remained up to 88 months follow-up assessments.

Liposuction was generally well tolerated; most adverse events occurred in <5% of patients.

However, **the quality of the evidence was limited**, with sources of uncertainty such as systematic biases due to lack of randomization, and the use of instruments that have not been validated for the collection of data and assessment in lipedema-related complaints.

Studies to validate tools to assess lipedema-related outcomes and define a minimally clinically important difference for the condition may also be necessary to put the benefit of liposuction for the treatment of lipedema in a clinical perspective.

**Revised guidelines on lipedema** were developed under the auspices of and funded by the German Society of Phlebology (DGP) (Reich-Schupke, et al., 2017).

The recommendations are based on a systematic literature search and the consensus of **eight medical societies and working groups**.

The guidelines stated that the diagnosis of lipedema is established on the basis of medical history and clinical findings and is characterized by localized, symmetrical increase in subcutaneous adipose tissue in arms and legs in marked disproportion to the trunk.

In addition edema, easy bruising, and increased tenderness may be seen.

Further diagnostic tests are typically reserved for special cases that require additional workup.

Lipedema is a chronic, progressive disorder with individual variability and unpredictability of its clinical course.

**Treatment consists of four therapeutic mainstays** that may be combined as necessary to address current clinical symptoms.

These four treatments include: complex physical therapy (manual lymphatic drainage, compression therapy, exercise therapy, and skin care), liposuction and plastic surgery, diet, and physical activity, as well as psychotherapy if necessary.

According to the Society, surgical procedures may be indicated if, despite thorough conservative treatment, symptoms persist, or if there is progression of clinical findings and/or symptoms.

**Halk and Damastra (2017), in a systematic review of the literature to June 2013, reported on Dutch guidelines for lipedema.**

In 2011, the Dutch Society of Dermatology and Venereology organized a task force to create guidelines on lipedema, using the International Classification of Functioning, Disability and Health of the World Health Organization.

Clinical questions on significant issues in lipedema care were proposed, involving making the diagnosis of lipedema; clinimetric measurements for early detection and adequate follow-up; and treatment.

The authors concluded that there is little consistent information about the diagnosis or therapy of lipedema in the literature and indicate lipedema is frequently misdiagnosed as only an aesthetic problem and therefore under- or mis-treated.

Treatment is divided into conservative and surgical treatment.

The guideline recommendations state:

“To ensure early detection and an individually outlined follow-up, the committee advises the use of a minimum data set of (repeated) measurements of waist circumference, circumference of involved limbs, body mass index and scoring of the level of daily practice and psychosocial distress.

Promotion of a healthy lifestyle with individually adjusted weight control measures, graded activity training programs, edema reduction, and other supportive measures are pillars of conservative therapy.

**Tumescent liposuction is the treatment of choice for patients with a suitable health profile and/or inadequate response to conservative and supportive measures”.**

The authors reported that consistent criteria to determine the ideal time or patient characteristics for liposuction are not available.

The strength of the recommendations in this clinical guideline and the links to supporting evidence were not provided.

## Return on Investment

This is another “work in progress”. I need more data to make this argument effectively. My goal is to illustrate that the cost to the patient, society, and *the insurance company* for liposuction for lipedema is greater for non-payment than payment. While many insurance companies may assert that their only concerned with the health of the patient and supporting only the most effective treatments, they also have shareholders so even if they explicitly may state this is not important. It might be useful to include some information. The only downside would be if the healthcare insurance carrier insisted on long-term ROI research studies comparing the costs of liposuction treatment versus conservative treatment. Obviously that type of research would be welcome and most useful–if it showed a positive net-benefit for the treatment.

**Benefits to the Patient**

Improving or restoring a patient’s mobility, functionality and normal gait, increases blood circulation and potential from bed sores due to prolonged periods of immobility.

**Benefits to Society**

If a patient is on Medicare or Medicaid, ultimately the American taxpayers will pay for their prolonged and worsening care.

Quantitative scores for fall risk. Quantitative measures of gait or postural stability can be captured using a variety of instruments or sensors or non-instrumental (e.g., **6 min walk**).

A person with impaired gait and mobility is more likely to fall and fracture a hip or leg with the subsequent expenses of hospital stays, treatment and therapies.

**Benefits to the Insurance Company**

The Health Insurance carrier has an obligation to the well-being of the patient as well as their shareholders. They are always evaluating how a cost today (liposuction) impacts future expenses (decreased mobility, lymphedema, and lipolymphedema). Obviously if the cost of liposuction for lipedema saves on future expense for the patient it is in the best interest of the carrier as well as the patient.

**National Estimated Costs of Obesity**

The medical care costs of obesity in the United States are high. In 2008 dollars, these costs were estimated to be $147 billion.

The annual nationwide productive costs of obesity obesity-related absenteeism range between $3.38 billion ($79 per obese individual) and $6.38 billion ($132 per individual with obesity).

In addition to these costs, data shows implications of obesity on recruitment by the armed forces. An assessment was performed of the percentage of the US military-age population that exceeds the US Army’s current active duty enlistment standards for weight-for-height and percent body fat, using data from the National Health and Nutrition Examination Surveys. In 2007-2008, 5.7 million men and 16.5 million women who were eligible for military service exceeded the Army’s enlistment standards for weight and body fat.

**Progression of Lipedema**

Advanced lipedema may progress into lymphedema

The combination of lymphatic insufficiency and lipedema is called lipolymphedema or lympho-lipedema

Poor gait and mobility will lead to a patient unable to perform many activities of daily living.

Obesity is technically not lipedema so these numbers may not be helpful–although they do provide perspective.

We need the best research and indications regarding before and *after Liposuction*.

1. Reduction in conservative treatment
2. Research and data
3. Reduction in mobility issues
4. Research and data
5. Reduction in treatment for lymphedema
6. Research and data

**Keyword / Verbiage List**

**General Notes**

Avoid "enhance aesthetics" or any verbiage considered cosmetic; confirm this with all your Providers and their office visit documentation.

Always include at least **two documents** of medical and scientific evidence [to support claim] (two policies indicated two)

“excluded…are procedures…that have not successfully completed a phase III trial“ [Molina healthcare].

One policy specifically referenced “United States research” which would omit a lot of foreign research on liposuction and lipedema.

**Unproven therapies** are treatments or procedures that lack significant medical documentation to support their medical effectiveness

Concerning getting an exemption to an E/I policy denial, often if the condition or disease is **life threatening or disabling** then the patient can appeal on that basis. Policies vary on this and there may be state regulations concerning life-threatening exemptions.

E/I are treatments that are currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine: clinical efficacy, therapeutic value or beneficial effects on health outcomes [Healthnet Policy–I consider this a rather strict interpretation]

Considered E/I...treatment progressed to limited human application, but has not achieved recognition as being proven effective in clinical medicine. [Wellmark]

**Use quantitative scores** whenever possible (e.g., decrease of pain, increase of mobility, six minute walk evaluation, risk of fall).

Some carriers define **defect** as: pain or other physical deficit that interferes with activities of daily living or impaired physical activity.