The Liposuction for Lipedema Medical Healthcare Carrier Reimbursement Guidebook

Lymph-Sparing Liposuction

by

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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.

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## Preface

My goal with this guidebook is to provide healthcare carrier reimbursement information for liposuction for Lipedema.

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 [Reimbursement Checklist](https://12uh.com/lipoforlipedemareimbursement/?s=checklist) available in the [Downloads section](https://12uh.com/lipoforlipedemareimbursement/downloads/) of the website. If you follow it meticulously with your Providers it should increase your probability of being reimbursed significantly.

You could focus on the checklist 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After extensive research (DEC 2020) into liposuction for lipedema reimbursement, I found a lot of information is vague, out-of-date, or incorrect.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-five 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.

Remember that many insurance adjusters will state that “liposuction is cosmetic.” Your mantra is:

“Liposuction for Lipedema is reconstructive and medically necessary; it is not experimental, investigational, or unproven. Research supports that it is both safe and effective in treating lipedema once all conservative measures have been exhausted.”

Repeat that to everyone you speak to, often until they’ve memorized it. You can shorten it to “reconstructive and medically necessary”, but you get the idea.

\*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. This process could take months and even a year or more. 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 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](#_Requesting_the_Carrier).” The reimbursement will be less for an “out of network” surgeon. Be sure to get all this in writing. 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 more than once—even if it takes months.

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. Once you win approval the amount the carrier reimburses becomes an issue if it is one-tenth of what the surgeon normally makes–for a much more difficult procedure. Some carriers have reimbursed the surgeons full fee. You just might have to work for it.
6. Don’t forget photographs! Make the case that this is reconstructive. Follow the reconstructive requirements with every Provider.
7. Keep it simple; work off the checklist. Use this Reimbursement Guidebook as a reference.
8. The fifteen-page [Request for Policy Evaluation document](https://12uh.com/lipoforlipedemareimbursement/request-for-reimbursement-policy-evaluation-for-liposuction-for-lipedema/) is also useful for your first appeal. It is a succinct argument for reimbursement with *fifty research references*.
9. [In-Network versus out-of-network](#_Requesting_the_Carrier); read your contract and get an “out-of-network” exception if no qualified surgeon is available In-Network.
10. Not all patients will qualify as reconstructive; those with the greatest decrease in functionality and mobility will be most likely; plus the patient *must* be healthy enough for the surgery.
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. 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.
13. 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 (DEC 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™, Ultrasound, 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 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.

## One-Page Checklist

This checklist may be all you need to know. Read it very carefully and take notes. Some line items have several pages of explanation (CPT codes, ICD-10-CM codes, Single Case Agreements, working denials, etc…)

Another concise document, not included in this Guidebook is my [Request for Policy Evaluation Document](#_Sample_Request_for). It is 14 pages long with 50 research references. The complete document, in MS Word format, is on my website. Note the focus of the document is for an evaluation of the carrier’s policy and not a single case. A carrier could decide to go into a 6-12 month medical review of liposuction for lipedema and delay your specific claim. I would use it as a cut-and-paste template, only send it on appeal, or send it after your claim is approved and paid.

One caveat is that while I recommend having all your information in place *before* you have the surgery and file the claim that may not always be possible. I would recommend getting in your claim *before* the surgery—even if you don’t have all your documentation.

See the checklist below:

1Determine with your managing Provider that all conservative measures have been exhausted and surgery is the next and only option. Asterisk \* [right] means additional information is available.

2Make a decision for surgery (in the future). [Website: www.lipoforlipedemareimbursement.com]

3Review your insurance policy for coverage information. [4] Read your carrier manual for exclusions.\*

5Check if there is a state or ins. Co. ombudsman or advocate. Medicare has one.\*

6Should you pay for a reimbursement advocate? See question list.\*

7Begin collecting Provider documentation 6 months or more in advance.8Obtain doctor letters and documentation. See below\*

9Find a qualified surgeon familiar with liposuction for lipedema.\*

10Many liposuction for lipedema experts are not contracted with insurance companies.

11Many liposuction for lipedema experts are not board-certified plastic surgeons.

12Most surgeons require payment up-front before pre-authorization and approval. Confirm.

13Most all approvals are case-by-case. Make your case the best.

14Is the surgeon in network or out? (Most likely not contracted and out of network).\*

15Plan may recommend an in-network board-certified plastic surgeon with no lipedema experience.

16If your surgeon is out-of-network you may need to negotiate a Single Case Agreement (SCA).\*

17Specifically request an "out-of-network" exception so they pay in-network fees.\*

18There are no fee schedules for liposuction surgery (reimbursement can be any amount; case by case).\*

19Establish number of treatments and that the ins. co. will reimburse.

20The more info you send with the pre-auth the better.\*

21The patient can provide a cover letter introduction and summary. Be concise and to the point!\*

22Send Photos with pre-auth info. Determine how best to deliver them.

23Expert Opinion Letters (EOL) need to support surgery as reconstructive and medically necessary.\*

24Recommend doctors document stages and [25] progression and how liposuction will help.\*

26Send documentation notes of at least six months of conservative treatment.

27Provider letters should state that all conservative treatments have failed and the progression of the disease will worsen without surgical treatment.

28If overweight address obesity management explicitly.

29Include all relevant doctor progress notes and diagnostic tests.

30Doctor must document that the patient has been compliant with all treatment.

31Address comorbidities and any safety issues concerning treatment.

32The treating physician must submit a Certification/Letter of Medical Necessity (LMN) form.33Get EOL letters from ALL your specialists!

34Obtain Pre-Authorization. Need approval, amount, and number of sessions.\*

35Get contact information from everyone you speak to! Ask for e-mails.

36Some ins. Co. will send your claim to an External Review Board. This may increase the approval time.\*

37If clinic does not file the claim you will need to submit the insurance claim.

38If the ins. co. agrees to pay the clinic (per SCA), submit CMS-1500 form; patient pay is the CMS-1490 form.\*

39Some ins. Co may approve in 3 weeks. Others may take months.

40Doctor confirmed. Send Compression stocking care doco.

41Doctor confirmed. Send Combined decongestive therapy (CDT) doco.

42Doctor confirmed. Send Manual Lymphatic Drainage (MLD) doco.

43Doctor confirmed. Send Lymphedema therapy doco.

44Doctor notes: surgery will improve functionality.\*

45Doctor notes: surgery will improve mobility and gait.\*

46Doctor notes: surgery will improve Quality of Life. [47] Doctor notes: include pain measurements.\*

48Doctor notes: "surgery will restore to a (more) normal appearance." [49] Add to above: "of a malformed body part."

50Once all documentation is assembled, contact the ins. co. for pre-auth; expect 3-12 weeks. Case-by-case.

51Send the ins. co. all requested information (and whatever additional you have).

52If denied you can appeal multiple times and levels; Medicare has five official levels.

## 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. The liposuction CPT codes are *not* in the Medicare fee schedule (no RVU’s [relative value units]) 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 [DEC 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 *administrative* guidelines as being “medically necessary”. That happens all too often. A service is 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. They are challenging the research.

**Reconstructive surgery** is approved if it is to “improve the function of a malformed body part.” [Medicare National Policy]. 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 (other carriers don’t).

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

[[Read Long Version Here](#_Experimental/Investigational/Unprov_2)] 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-CM codes for lipedema. Is that accurate?**

Currently (DEC 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 (DEC 2020) that Providers have used the unlisted code–and even 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). Neither selection is correct or false—all that matters is what the insurance company accepts and reimburses. Your surgeon should have some knowledge of what has been paid and denied in your area. I would check with them first. I have information on the new term later in this document.

\* [Fibro-Lympho-Lipo-Aspiration (FLLA).](#_Fibro-Lympho-Lipo-Aspiration_(FLLA)_1)

## 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 has multiple definitions: (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.

## 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 [DEC 2020]. It is on my [website](http://www.lipoforlipedemareimbursement.com) so you can cut and paste it into your pre-authorization and appeal documentation. Read the information below very carefully.

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.

In mid-August, 20202, I have had numerous conversations with patients and office managers and advocates. The feedback I’ve been receiving is that most carriers *are* reimbursing for liposuction for lipedema including: United Healthcare, Aetna, Blue Shield of California and Tricare. Cigna has a formal denial policy so I would expect them to be particularly difficult. Numerous carriers include vague language regarding cosmetic versus reconstructive that suggest that if you make your case you will be reimbursed.

**Most carriers reimburse on a case by case basis**. Whether you are approved will depend on how well you demonstrate that your case is “reconstructive and medically necessary”, and even the account rep you work with. Some might hear “liposuction” and tune you out. I would use that phrase with all the insurance reps.

**The reason I ask for so much information up front** is that we want to win approval up-front and not have to appeal. Like the person putting on sneakers to outrun the lion says to his (ex) friend, “I don’t have to outrun the lion, I only have to outrun you.” You want your case to be overwhelming—and the most compelling. It does not need to be an advanced stage—it just needs to be conclusively medically necessary. That is your hurdle. Aim for the top of the list. After you have collected all your documentation, in order the issues are:

1. Get **pre-approval for the procedure**. Even if the pre-authorization is denied you still must file the claim and follow up with appeals.
2. If approved determine if your surgeon is **In-Network** or **Out-Of-Network**. If out then you will need to make your case that the other surgeon is not qualified and your surgeon is. Most insurance carriers will simply assign the nearest, in-network, board-certified plastic surgeon.
3. Determine if a **Single Case Agreement (SCA)** is necessary; with one the carrier will pay the surgeon and the surgeon must accept the payment. Note that some surgeons may be reluctant to accept the payment and clause that prohibits *balance billing*, which is the remainder after the insurance pays. In other words, most carriers will require the surgeon to accept their payment in full; if the payment is too low the surgeon will not accept the agreement.

These are three important but separate issues. Winning approval as reconstructive is only part of the battle. Most surgeons,’ expert in liposuction for lipedema, are *not* in-network. Some are not contracted with *any* insurance carriers—they operate a strictly cash business (that is mostly cosmetic).

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 Liposuction for Lipedema 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.

There are currently (DEC 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 (DEC 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 (DEC 2020) there is no ICD-10-CM diagnosis code in the United States specific to Lipedema. A submission for new codes was presented September 9, 2020 by Karen Herbst, Phd., MD to the NCHS/CDC.

The main goal is to adopt the International ICD-10 codes for lipedema, with stages, and a separate code for lipolymphedema. If accepted the new codes will be included 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. In the meantime, 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 (DEC 2020); you claim will be rejected.

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 (mostly used in Germany and Austria) specify stages 1-3 but not types. **Type classifications** indicate the **affected areas of the body.**

Stage classifications look at the condition of the skin and tissue. Type is by location.

**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 different *types* of liposuction. Words matter and perception matters. 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. It’s a little technical so feel free to skip it and go with the term and phrasing your surgeon uses.

**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.

The three most common terms are: Lymph-Sparing, Tumescent Liposuction, and Water-Assisted Liposuction (WAL). 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 is a list of terms found in research literature:

(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.]

**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*.

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. 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. **Tumescent Local Anesthesia** (TLA) is a medical acronym found in several research studies.

**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)]. Surgeons expert in lipedema *often* use more than one technique/modality.

**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 VASER® liposuction in addition to WAL and PAL [[More Here](https://lipedemaliposuctioncenter.com/vaser-liposuction/)]. Dr. Michael Schwartz uses a combination of US and PAL.

**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).

**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.

The procedures below are not appropriate for liposuction for lipedema.

**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’s 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.

## 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, laser, 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. In the Appendix I have information on [Fibro-Lympho-Lipo-Aspiration (FLLA)](#_Fibro-Lympho-Lipo-Aspiration_(FLLA)_1); this is yet another name for the procedure. If you are successful in differentiating cosmetic liposuction from reconstructive an insurance representative could determine that the current SAL codes are insufficient and recommend the unlisted CPT code. This term would require a new CPT code specifically for reconstructive liposuction for lipedema.

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

## Preparing to File the Claim

This is a new section created from patient feedback in summer of 2020.

1. Collect and submit your pre-approval documentation for the procedure. Most important are Expert Opinion Letters (EOL) and photos.
2. Determine if your surgeon is [In-Network or Out-Of-Network](#_Requesting_the_Carrier). If out then you will need to make your case that the In-Network surgeon is not qualified and your surgeon is. Most insurance companies will simply assign the nearest board-certified, plastic surgeon. Many of these will have little experience with liposuction *for lipedema*.
3. Determine if a [Single Case Agreement](#_Single_Case_Agreement) (SCA) is necessary.
4. I have included instructions on [how to submit the CMS-1500](#_How_to_fill) or the [CMS-1490 claim form](#_CMS_1490_Form).

**Liposuction for Lipedema Reimbursement**

**This document includes information on:**

1. **Single Case Agreement (SCA) with Insurance Companies**
2. **CMS-1500 Form**
3. **CMS-1490 Form**

Note that the most common claim form is the CMS-1500 form. This is what medical clinics use for professional services. (A hospital bills on a separate form, the UB-04). If you work out a Single Case Agreement (SCA) with and insurance company you will fill out the CMS-1500 form.

Many cosmetic surgeons are not contracted with Medicare, Medicaid, or private insurers. They are strictly a cash-only business. Their staff has neither the time, personnel or expertise on how to file a claim or get you paid.

If you don’t have an SCA agreement and the clinic cannot or will not file a claim, you can fill out the CMS-1490 form. Technically this is a Medicare claim form. A private insurance carrier like Anthem, Aetna, Cigna, Human, or United Healthcare may request or require it or the CMS-1500 form. Essentially the information is the same and your focus—proving that the procedure is reconstructive and medically necessary is the same as well. Work with your surgeon regarding which ICD-10 diagnosis codes and CPT™ code to use. Be sure to get the surgeons NPI number. The information below is a step-by-step review of the boxes on the CMS-1500 form. I have additional sample forms and official instructions on my website. The [CMS-1490 instructions are here](#_CMS_1490_Form).

**How to Negotiate a Single Case Agreement for an Out-of-Network Provider**

These agreements occur between insurance companies and Out-of-Network (OON) providers in which the OON clinic is recognized as an In-Network (INN) provider.

While **it is usually the patient who asks their insurer for the SCA**, on the basis that there are no other INN providers available for liposuction for lipedema in their area, the practice will have to come to agreement about terms and rates for the services that will be provided. Since insurers are not legally required to provide an SCA, it will be vital for you to present to the medically necessity and reconstructive nature of the procedure (and contrast it with cosmetic liposuction).

In most cases, the liposuction for lipedema specialist will be a new provider, in a different city and out-of-network. Therefore existing patient issues such as continuity of care won’t be an issue.

Until an SCA has been granted, the Provider should clearly define the patient’s financial responsibilities to the clinic. It is best to wait until the SCA has been authorized or a financial arrangement is made for the procedures.

Always request an SCA for OON plans when applying for prior authorization. Consider the following strategies to help you obtain a Single Case Agreement:

**Request the SCA at the same time as the Initial Assessment Authorization**

Prior to the contract being signed, the patient will need to negotiate fees based on your fee schedule. Remember that the AMA CPT™ liposuction codes have no Medicare RVU’s (Relative Value Units) and therefore there is no generally established fee schedule for the procedure (in other words, the carrier can pay any amount but won’t have much knowledge or experience concerning the time, resources, and expertise necessary for the procedure). If approved, expect reimbursement as low as $1,200 per procedure although we have had reports of providers receiving their full fee (of $15,000) per procedure. It all depends on the carrier and sometimes who you speak with at the carrier.

An insurance representative will seek out qualified providers who are in-network so be prepared to substantiate your argument (that none are available). You may be required to work through the INN process. An SCA may be allowed under “pay at highest in network rate”, which means you will be able to provide the service, but not negotiate your own rates.

If an SCA is granted, pay attention to the **date range** that is applied to it. Be sure to note the number of sessions (procedures).

Take note that some insurers require the SCA be in the **Rendering Provider’s name** which can affect information on a CMS-1500 claim form.

**Noridian Medicare CMS-Form Guidelines and Tips**

All paper claims must be submitted on the Revised Form CMS-1500 (02/12). This form is the only version accepted by Medicare. Most private insurers follow Medicare guidelines (but not all).

**Responsibility for Accurate Claims**

The supplier is ultimately responsible for the accuracy of claims filed for his/her services. We recommend the supplier's office set a policy to ensure all necessary information is included on the initial claim submission and the information is correct. Suppliers may refer to the CMS-1500 instructions for guidance on completing the claim form.

**Guidelines for Filing Paper Claims**

Failure to follow these guidelines could cause a delay in processing, denial of the claim, or affect payment accuracy.

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare unless a supplier meets certain "exceptions" described within the law. View exceptions on the Administrative Simplification Compliance Act Self Assessment.

**CMS-1500 Claim Form Instructions**

Complete instructions for the CMS-1500 claim form are provided in the CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Publication 100-04, Chapter 26

**Tips for Submitting Clean Paper Claims (from Noridian Medicare)**

Noridian uses optical character recognition (OCR) to process paper CMS-1500 claim forms. OCR is a means of inputting text into a computer. It involves scanning a paper document to create a digital image of the text and then using software to store knowledge about that digital image. With OCR, it is very important suppliers follow proper paper claim submission guidelines.

**Font and Printing**

* Use Courier New font for computer-generated claims. Do not print in italics, bold or script. Do not mix fonts.
* Use Pica 10 or 12-point typeface for claims typed on a typewriter.
* Do not type in italics or script.

**Use upper case letters for all claim data.**

* Ensure none of the characters touch.
* Ensure no lines from the printer cartridge are anywhere on the claim.
* Do not use special characters, (dollar signs, decimals, dashes, asterisk, or backslashes) unless otherwise specified.

Use an ink jet or laser printer to complete the CMS-1500 claim form. Because claims submitted with dot matrix printers have breaks in the letters and numbers, OCR equipment is unable to properly read these claims. Suppliers using dot matrix printers risk slow or incorrect processing of their claims.

**Ink Color**

* The OCR equipment is sensitive to ink color. Follow these guidelines on ink color:
* Submit the scannable, red-ink version of the CMS-1500 claim form.
* Do not use red ink to complete a CMS-1500 claim form. OCR scanners "drop out" any red that is on the paper.
* Use true black ink. Do not use any other color ink such as blue, purple, or red.
* Avoid using old or worn ink cartridges, toner cartridges, or printer ribbons.

**Alignment**

To process a claim correctly, proper alignment of the CMS-1500 form information is necessary. The OCR equipment may not read information that is not aligned properly, resulting in unnecessary denials or incorrect payment. To properly align data on the claim form, do the following:

* Center information vertically within the confines of each box on the CMS-1500 claim form.
* Align all information on the same horizontal plane.
* Do not include more than six line items on a CMS-1500 claim form.
* Do not squeeze two lines of information on one line.

**Handwritten Claims**

Handwritten claims are difficult to read; therefore, they take longer to process. The OCR equipment may misread the information, resulting in the entry of invalid information for the claim. To ensure timely and accurate processing of claims, Noridian recommends claims be typed, not handwritten.

**Preprogrammed, Preprinted Information**

Do not use preprinted or preprogrammed information on the CMS-1500 claim form. An example of preprinted or preprogrammed information is a pointer of "A" in Item 24e on all six detail lines but only submitting one claim detail line.

The areas of most concern for preprinted or preprogrammed information are Item 24 and the bottom of the claim form. Preprinted information in these areas cause the OCR equipment to read information not intended for the specific field, resulting in an Education Status letter.

**Ordering CMS-1500 Claim Forms**

In order to purchase claim forms, contact the U.S. Government Printing Office at 1-866-512-1800, local printing companies, and/or office supply stores. Each of these vendors sells the CMS-1500 claim form in its various configurations (single part, multi-part, continuous feed, laser, etc).

A box of 250 CMS-1500 forms will run about $17. While that is not much, you may have 249 forms you will never use! Best advice is to ask your primary care provider for a few CMS-1500 forms or any of your specialists. Some may not have any as most all claims are submitted electronically.

**Electronic Claims**

Electronic Data Interchange (EDI) provides the ability to quickly and efficiently exchange healthcare information in a safe, secure, and cost-effective way. Electronic claims are transmitted to the Common Electronic Data Interchange (CEDI) This link will take you to an external website. contractor. After the electronic claim has been accepted by the CEDI, the claim is then transferred to the appropriate DME MAC for processing based on the beneficiary's address listed on the electronic claim.

To learn more about EDI, contact CEDI This link will take you to an external website..

Last Updated Feb 11 , 2020

**Sample SCA form**

<https://www.signnow.com/jsfiller-desk15/?projectId=503087355#bcc86d30a5bbff70a03f6a1127c87f57>

## Single Case Agreement (SCA) with Insurance Companies

Reconstructive Surgery, Insurance, **Out-of-network providers**

**Making the case for single case agreement (SCA) with insurance companies**

Most cosmetic surgeons have chosen not to be a part of any insurance panel. Patients pay directly for services (out-of-pocket).

Most SCA’s are to pay the surgeon directly. If your surgeon is not in-network and not planning to file he claim for you must discuss with him/her that you are applying for an SCA and whether it will be accepted. Some surgeons don’t like them because the reimbursement rate is much lower than their out-of-pocket rate.

If the surgeon will not accept the payment then you must negotiate with the insurance carrier to pay you directly. To file the claim the clinic needs to provide the Superbill (a statement listing the dates, service codes and payments made) which they submit for reimbursement to their insurance company. **Note:** Many cosmetic/plastic surgery clinics do not use a Superbill (an artifact from manual systems). Many may not have a practice management system and be unfamiliar with filing insurance. The patient will have to create and submit the claim.

A **Single Case Agreements (SCAs**) can be beneficial to all parties involved; it is a contract between an insurance company and an out-of-network provider for a specific patient, so that the patient can see that provider using their **in-network benefits** (i.e., the patient will only have to pay their routine in-network co-pays for treatments after meeting their in-network deductible [if any]). The fee for the service paid by the insurance company is negotiated by the insurance company and the provider as part of the SCA.

An SCA is not *always* required for the insurance carrier to pay the clinic; your carrier may decide to pay the clinic without one. However, without one the carrier is more likely to elect to pay the patient directly.

**What are the conditions to be met to ask for a Single Case Agreement (SCA)?**

An SCA has to basically address the unique needs of the patient and the cost benefits to the insurance company of the patient seeing you, rather than an in-network provider. The following are some of the conditions that must be met for an SCA to be granted. For a new potential patient:

* You have a specialized service (liposuction for lipedema) that is not available with any of the in-network providers.
* Geographical location - in-network providers (lipedema expert) are not available locally
* Treatment you provide that will keep the patient out of the hospital, or will reduce the cost of conservative treatment.
* If the patient is unable to find an adequately skilled in-network provider, then the patient makes the case for an SCA with the out-of-network provider *before* commencing treatment.
* For a current patient who has obtained a new insurance.

**Continuity of Care** (generally this won’t apply to Liposuction for Lipedema – Jeff)

When can one make the case for Continuity of Care?

If the patient has recently changed insurance providers, then the insurance company can agree to a limited number of treatments (around 10) and period (e.g., 60 days since insurance change), to allow the patient to continue treatment with the current out-of-network provider, while transitioning to an in-network provider. If there is evidence that the individual might be a danger to him/herself or others, or if it would adversely affect the patient psychologically/mentally (such as setbacks in the progress made in therapy), if required to transition to an in-network provider, than a case could be made for extended continued care with the current provider. Examples: a patient has an insecure attachment and finds it very hard to trust others. The therapeutic relationship that has already been established with the current provider may qualify as a factor for granting the SCA.

**How does one negotiate the rates of payment and terms of the contract?**

Insurance companies are *legally obligated* to provide patients with adequate treatment by properly trained professionals. Therefore, if the insurance plan does not cover any out-of-network services, *and* there are no in-network providers with the given specialty, then negotiate the surgeon’s **customary full fee** as the rate for new patients. This is because the patient is not simply choosing to see this particular surgeon, but is being forced to, with inadequate in-network providers. Some use a reimbursement advocate for the negotiation. Others negotiate on their own behalf. If your own efforts are not enough or you are uncomfortable with the negotiations you may consider hiring a healthcare attorney familiar with “breach of contract” suits in your state if you experience a lot of pushback.

In this case, **the patient usually makes the case with the insurance company for an SCA with the Provider, before commencing treatment**.

Sometimes an insurance company may have a policy of "pay at highest in-network rate", in which case you will not be able to negotiate the rate. The surgeon has the option of declining the SCA if the rate and terms are not acceptable.

The SCA will also spell out the **CPT™ and ICD-10-CM codes** authorized, the start and end dates for treatment, and the number of treatments (typically two or more). Note again, that both the surgeon and the insurance company may be unfamiliar with the different codes used and that there is not 100% agreement or Medicare or AMA CPT™ Coding Assistant™ advice.

## Requesting the Carrier Pay an Out-Of-Network Surgeon as In-Network

This is part of the SCA. What you must do:

1. We are assuming that you’ve passed the approval hurdle, the surgery has been deemed to be reconstructive and medically necessary and not cosmetic. You have also discussed the number of procedures required (typically at least two, depending on severity).
2. Often the insurance carrier will assign the nearest, board-certified plastic surgeon.
3. Note that unlike cardiology or oncology, liposuction for lipedema is not a specialty. In fact, not every surgeon experienced in liposuction for lipedema is a board-certified, plastic surgeon. Many are primarily cosmetic surgeons and may be specialized in liposuction techniques. As a result, they may be a “cash-only” business and neither file claims or have a staff knowledgeable about reimbursement. They may be of very little assistance.
4. Some are certified through other associations, such as the American Board of Cosmetic Surgeons (unfortunately we want to steer clear of that “cosmetic” term.) Some are not plastic surgeons. Technically, one need not be classified as a “surgeon” to perform liposuction. This is a distinction that the patient needs to be aware of. Many insurance companies and the American Society for Plastic Surgeons recommend that only a “board certified” plastic surgeon performs the surgery.
5. Explain that liposuction for lipedema procedure is different than cosmetic liposuction.
6. Explain that experience and training matters and the total number of procedures performed relating to lipedema is relevant.
7. Now the issue is who will do the surgery and the issue is that you don’t believe anyone local, or in-network surgeon is qualified.
8. If you are requesting both approval and an out-of-network exception note that the delay may be much longer (than three weeks, for example) and these are two separate issues.
9. Read your carrier manual for instructions and definitions of getting an “out-of-network exception.” Some call it a “network gap exception.” They should provide instructions for the process.
10. Remember that every insurance company is different, every case is different, and success may depend on the individual account representative. Don’t assume anything and document names, times and actions.
11. Provide the out-of-network provider’s contact information.
12. Provide a date range during which you expect to receive the requested service. For example, from Sept 1, 2020, to Dec 31, 2020. I would make the date no sooner than three weeks; some insurance will take three months to decide.
13. Provide the names of any in-network providers of the same specialty within your geographic area along with an explanation as to why that particular in-network provider isn’t capable of performing the service.
14. You could compare number of liposuction for lipedema procedures performed per year or lifetime as a benchmark.
15. There are relatively few surgeons expert in liposuction for lipedema. Some estimate the number is fewer than 25 nationwide.
16. There is no in-network provider capable of providing the service you need within a reasonable distance. Each health plan defines for itself what a reasonable distance is.
17. You should ask for the network gap exception prior to getting the care.
18. You may need to include the ICD-10-CM and CPT codes in your request. I have more on these in the Reimbursement Guidebook.
19. The three most common ICD-10-CM codes used for lipedema, in order of usage, are: R60.9 Edema; Q82.0 Familial Hereditary Edema; and E88.2: Adiposis dolorosa; Lipomatosis dolorosa (Dercum’s disease). There is no exclusive lipedema code.
20. For CPT™, the most common code is: 15879: Suction assisted lipectomy (SAL); lower extremity. 15876 is SAL for the head and neck; 15877 is SAL for the trunk, and 15878 is SAL for the upper extremities.
21. The “Gotcha” on the codes above is that your argument is that the procedure is *not* SAL but more complicated; if the insurance agent makes an issue of this (you cannot use the code and then argue that it’s not accurate or appropriate) and you cannot get around it, then you would need to use an unlisted CPT™ code: 38999 (unlisted procedure, hemic or lymphatic system). This creates more problems but is not unsurmountable.
22. If you have not met with your preferred surgeon then I would go with the R60.9 ICD-10-CM code and the 15879 for SAL for the lower extremities with the caveat that there are other codes that should be accepted.
23. Talk to your surgeon if they have had success in getting out-of-network exceptions with a particular insurance company.
24. If your request for an out-of-network is denied, don’t give up. Many states have laws requiring plans to cover such out-of-network services at in-network rates. First determine the reason and provide a rebuttal. If your request is still denied, federal or state law may require your insurer to allow you to start an “external” appeal.
25. If the appeal process drags on, you may ask your surgeon if you could make an up-front payment but put the surgery out 3 months or more. An out-of-network surgeon may not be willing to spend additional time with you if they feel that you may decide to go in-network.

\*\*\*

This is a request for a network gap exception to cover liposuction for lipedema, a unique, reconstructive, medically necessary procedure from [Dr Smith] and out-of-network provider at the in-network rate.

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. The procedure goes by many names:

1. Tumescent Liposuction
2. Lymph-Sparing Liposuction
3. Lymph-Sparing, Tumescent Liposuction
4. Water-Assisted Liposuction (WAL)
5. Power-Assisted Liposuction (PAL)
6. It can simple be called **reconstructive/medically necessary liposuction** **for lipedema** (to differentiate it from cosmetic liposuction).
7. [[1]](#endnote-1)

One description of the liposuction for lipedema modification is **Fibro-Lympho-Lipo-Aspiration (FLLA)\***. The term is specifically referenced in the paper below (I have access to the full abstract if you’re interested):

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.

\* Don’t concern yourself with the FLLA term if you find it confusing. Most surgeons have never heard of it either. Just note the detailed description of the procedure and the point that it is much different than cosmetic liposuction in terms of skill, time involved, focus and outcome.

**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 from contouring, cosmetic liposuction. Only small blunt cannulas are used, great care is used to not injure lymphatic which are already abnormal and increased risk of injury.[[2]](#endnote-2) Only the longitudinal orientation of cannulas is used at critical junctures. Preoperatively critical lymphatic structures are scanned and marked. **The surgery averages 4-5 hours**, due to the removal of 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.

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.[[3]](#endnote-3)

Lymphatic stasis results in dermal fibrosis, deposition of proteoglycans and fibrosis in the matrix, and excess adipose tissue accumulation.[[4]](#endnote-4) [[5]](#endnote-5)

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.[[6]](#endnote-6)

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**.

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.

For liposuction for lipedema, 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.

## Reimbursement for Liposuction for Lipedema

The first hurdle is getting approved for reconstructive, medically-necessary liposuction for lipedema. The second is how much reimbursement? How much will the carrier pay your surgeon? Most patients have at least two surgeries. So whether the charge is $8,000 or $15,000 per procedure the cost is doubled. And for more severe cases there could be more surgeries plus surgery for the upper extremities if warranted.

One surgeon offered that the free market valuation of lipedema surgery is from $7-$30K. Typically it’s highest the closer you get to Beverly Hills. Below are the top highest paying procedures in terms of total RVU’s and Medicare allowable (2020):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **0HCPCS** | **DESCRIPTION** | **TOTAL** | **Medicare** |
|  |  |  | **FACILITY RVU'S** | **Allowable** |
| 1 | 39503 | Repair of diaphragm hernia | **173.2** | $ 6,250.79 |
| 2 | 47135 | Transplantation of liver | **157.05** | $ 5,667.93 |
| 3 | 43116 | Partial removal of esophagus | **145.06** | $ 5,235.22 |
| 4 | 49605 | Repair umbilical lesion | **144.61** | $ 5,218.97 |
| 5 | **33935** | Transplantation heart/lung | **143.67** | $ 5,185.05 |
| 6 | **32854** | Lung transplant with bypass | **141.2** | $ 5,095.91 |
| 7 | 33945 | Transplantation of heart | **141.12** | $ 5,093.02 |
| 8 | 61698 | Brain aneurysm repr complx | **138.04** | $ 4,981.86 |
| 9 | 47142 | Partial removal donor liver | **137.42** | $ 4,959.49 |
| 10 | 61686 | Intracranial vessel surgery | **134.17** | $ 4,842.20 |

The take-away here is that it would be difficult to justify the typical fee for liposuction for lipedema using comparable procedures. No single procedure is higher than 173.2 RVU’s or $ $ 6,250.79. Note that this is only the payment to the surgeon for a single procedure—it does not include the hospital costs, which will be much higher, and additional procedures billed during a single operation.

We have had reports of payments of about $1,200 (~33 RVUS) for procedure. While that may be reasonable—RVU-wise—no surgeon wants to accept that as payment in full. It is also difficult to determine which procedure would be comparable to the procedure—in order to develop an RVU baseline for lipedema for lipedema.

At best you would pay the surgeon and receive the $1,200 from the carrier. With that said, we have had reports of carriers paying the full fee or 80% of the full fee submitted. That’s great news. However there is no particular rhyme or reason for why they paid the full amount. The best advice is to provide the detailed explanation of the procedure above and include whatever your surgeon charges.

**How carriers pay**

Carriers pay in different ways. How they pay is specific to that carrier and there is no way to know, without asking or finding it in their payment policy what their payment methodology is.

**They pay a percent of the Medicare fee schedule.** This is typically higher, 130% to 150% or more of what Medicare pays. The liposuction CPT codes (15876-15879) and the unlisted CPT code: 38999 **have no RVU’s** and therefor no Medicare allowable amount. So there is nothing to pay a percent of here.

**They have their own Fee Schedule**. Most all fill follow Medicare and RVU’s they don’t have to follow it exactly. They could develop their own fee schedule for services.

**They pay a percent of charges**. This is what you want. If your carrier agrees to pay 100% or 80% of whatever is billed that is great for you. While I have heard stories where “they paid the full amount” generally that is not a payment policy. Most all Providers charge more than Medicare, often 150% to 200% of the Medicare allowable for all their services—across the board. The difference is written off as a “contractual write-off” meaning that you are contractually accepting the insurance payment in-full and writing off the remainder (not billing the patient.)

## How to fill out a CMS-1500 Form

If your surgeon is not contracted with your insurance carrier you will need to request a Single Case Agreement (SCA) between the carrier and your surgeon and prepare and file the claim form yourself (assuming the surgeon does not file insurance claims). Essentially you are requesting that, specifically for your case, the insurance company pays the surgeon for the service as reconstructive and medically necessary and you’re negotiating both for reimbursement *and* an amount.

A provider is In-Network if they have a contract with the insurance carrier or Medicare. Most likely your surgeon will be Out of Network. This is a different issue. When you contact the insurance company concerning the SCA, you must request an “out of network” exception because no one expert in specifically liposuction for lipedema is available in-network. Note that Medicare has different levels:

**Opt-out providers** do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. This means they can charge whatever they want for services.

Medicare will not pay for care you receive from an opt-out provider (except in emergencies). You are responsible for the entire cost of your care.

The provider must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of your care and that Medicare (or a private insurance company) will not reimburse you unless you have negotiated a Single-Case-Agreement (SCA). Also note that liposuction is considered by Medicare (and most private insurors) to be cosmetic and there is no standard reimbursement assigned. Some Medicare jurisdictions do include verbiage stating that a service is not covered unless determined to be “reconstructive and medically necessary.”

Opt-out providers do not bill Medicare for services you receive.

**Non-participating providers** accept Medicare but do not agree to take assignment in all cases (they may on a case-by-case basis). This means that while non-participating providers have signed up to accept Medicare insurance, they do not accept Medicare’s approved amount for health care services as full payment.

Depending on which form you need, I recommend downloading a copy of the form and review several instruction tutorials. I’ve [posted claim form instructions](https://12uh.com/lipoforlipedemareimbursement/cms-1500-and-cms-1490-s-claim-form-instructions/) to my website. Note that you *cannot* print out a PDF version of the form, fill it out and send it. It must be a pre-printed CMS-1500 claim form, prepared with special red "drop out" ink that can be scanned using an OCR (Optical Character Recognition) scanner. See the sample CMS-1500 form at the link below.

<https://www.cigna.com/static/www-cigna-com/docs/health-care-providers/form-cms1500.pdf>

The Administrative Simplification Compliance Act (ASCA) **requires** payment of services or supplies be submitted to Medicare **electronically**, with limited exceptions. Medicare will receive and process paper claims from health care professionals and suppliers who meet the exceptions to the requirements set forth in the ASCA.

**Option One:** A physician, practitioner, or supplier that bills a Medicare Carrier, A/B MAC, or DME MAC and has fewer than 10 Full-Time Equivalent (FTE) employees.

**Option Two:** You can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically. While most private insurer follow Medicare guidelines, some do not so some may have their own rules or guidelines for submission.

Do not fill out the CMS-1500 form by hand. It must be typed. More detailed instructions on the format is provided later in this document.

**Line Items**

Follow the Instructions\_for\_CMS\_1500\_Claim\_Form PDF document. Some boxes (fields) are required; some are not. I did not include obvious requirements like the patient’s name and address.

**Box 14:** Date current illness (Lipedema) was first diagnosed or onset.

**Box 17**: Referring doctor: You need to insert your primary care physician here:

**Box 17a:** Referring doctor ID: Enter the state medical license number.

**Box 17b:** Referring physicians NPI number (ask). You can look these up on the Internet as well.

**Box 19:** Reserved for Local Use: enter comments here. For example: Dx=Lipedema stage 3 or Unlisted procedure: Tumescent Liposuction for Lipedema or Lymph-sparing Liposuction or Water-Assisted- Liposuction (WAL) for Lipedema.

**Box 21: ICD-10 codes:** You Providers should provide the codes but note that there is no specific code in ICD-10-CM for Lipedema. The three, in order of usage, are:

R60.9 Edema (this code is in the index as a crosswalk for Lipedema)

Q82.0 Familial Hereditary Edema (Lipedema is considered an inheritable disease)

E88.2: Adiposis dolorosa; Lipomatosis dolorosa (Dercum’s disease) (Lipedema is considered a metabolic disease; this is the category recommended for specific a specific ICD-10-CM code in the future)

Include codes for pain, abnormal gait, and other functional impairments, if any.

**Box 23:** Enter the prior authorization number if one is obtained. Even if the carrier won’t provide authorization file the claim anyway.

Box 24a: Dates of service for the procedure.

Box 24b: Place of service for the procedure. If performed in the office the code is 11. An ambulatory surgery center is 23; an outpatient hospital is 22. If the patient is admitted to the hospital the code is 21. Note that a hospital admission will also incur hospital charges (Medicare Part-A if a Medicare patient) in addition to the surgeon’s professional fees.

**CPT™ code:** There are four liposuction CPT™ codes based on location. They read: “Suction-Assisted Lipectomy” (SAL = liposuction). Some carriers might argue that the SAL codes is a cosmetic code. Essentially you are arguing that, specifically for Lipedema, the procedure is reconstructive and medically necessary. Some use the unlisted CPT™ code 38999.

15877: Suction assisted lipectomy; trunk

15878: Suction assisted lipectomy; upper extremity

15879: Suction assisted lipectomy; lower extremity (most common)

38999: unlisted procedure, hemic or lymphatic system

If you use the unlisted code (38999), be sure to include the description (e.g., lymph-sparing liposuction for Lipedema) in Box 19 (aka comments). Some surgeons and consultants believe that the technique and procedure for Lipedema is different enough from the established CPT™ codes that the existing codes are not accurate. If you are given no advice or feedback from your surgeon I would go with the existing CPT™ code: 15879.

Box 24D: Enter the CPT™ code here

Box 24E: Link the procedure to the ICD-10 Lipedema code with the letter next to the ICD-10 code.

Box 24F: Enter the amount charged here

Box 24G: Number of units

Box 24J: Enter the surgeon’s NPI number

Box 25: Enter the clinic or doctor’s federal tax ID number.

Box 26: patient’s medical record number (optional)

Box 27: Accept Assignment? If you are filling out the form then your Provider does not accept assignment (the insurance carrier pays you unless there is an SCA signed).

Box 28: Total charges. Do not include decimals. Do not leave blank.

Box 31: Signature of the surgeon and credentials

Box 32: Provider name and address with a nine-digit zip code without a hyphen and phone.

Box 32a: service facility location information – enter the NPI of the facility where the services were rendered

Box 32b: service facility location

Box 33: Billing Provider information and phone; confirm that the Provider is paid per the SCA instead of the patient.

Box 33a: billing provider NPI

Box 33b: used for atypical providers only.

## How to fill out a CMS 1490-S Claim

On the website and the CMS website there is a 1490-S Patient’s Request for Medical Payment PDF form that is editable. You can enter your information directly into the form, save it and send it. You don’t want to fill it out by hand.

Fill in all your contact information.

Section 2: Enter your ICD-10 and CPT codes and descriptions here. See the information above and the Reimbursement Guidebook for additional information. Per the form be sure to include:

* Date of service
* Place of service
* Description of illness or injury
* Description of each surgical or medical service or supply furnished
* Charge for each service
* The doctor’s or supplier’s name and address
* The provider or supplier’s National Provider Identifier (NPI) If known [Ask the office manager for this; alternatively you can look these up on the Medicare website – Jeff]. [Here is one NPI lookup link](https://npidb.org/)

This document is simple and straightforward. Check No for the four “related to” questions and enter any information about other insurance.

This is a generic form and it assumes the procedure or service is on the Medicare fee schedule. Liposuction is not on the fee schedule and has no Medicare RVU’s (standard payment). Therefore you will have to begin the conversation with:

“Liposuction for Lipedema, (aka Lymph-Sparing Liposuction, Tumescent Liposuction, or Water-Assisted Liposuction) is reconstructive and medically necessary; it is not experimental, investigational, or unproven. Research supports that it is both safe and effective.”

## 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

## How to use Research to Reverse Denials

Your main weapon against the E/I/U argument is peer-reviewed research that proves the efficacy, safety, 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. I currently have 150 full abstracts—it’s not all of the top research papers but many of them. The missing ones are all available if you’re either a researcher or pay a fee.

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. The Lipedema Foundation Website below has a good list of research papers and books.

<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’s 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 [DEC 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 Issue 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.

[Wiley Online Library](https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2133.2011.10566.x) [CAS](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=32&doi=10.1002%2Foby.22597&key=1%3ASTN%3A280%3ADC%252BC387htFGisQ%253D%253D) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=21824127) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000300695900053)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=166&publication_year=2012&pages=161-168&journal=Br+J+Dermatol&author=W+Schmeller&author=M+Hueppe&author=I+Meier%E2%80%90Vollrath&title=Tumescent+liposuction+in+lipoedema+yields+good+long%E2%80%90term+results)

66. 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; **9**: 33‐ 40.

[Wiley Online Library](https://onlinelibrary.wiley.com/doi/10.1111/j.1610-0387.2010.07504.x) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=21166777) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000285391600006)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=9&publication_year=2011&pages=33-40&journal=J+Dtsch+Dermatol+Ges&author=S+Rapprich&author=A+Dingler&author=M+Podda&title=Liposuction+is+an+effective+treatment+for+lipedema%E2%80%90results+of+a+study+with+25+patients)

74. Halk AB, Damstra RJ. First Dutch guidelines on lipedema using the international classification of functioning, disability and health. *Phlebology* 2017; **32**: 152‐ 159.

[Crossref](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=16&doi=10.1002%2Foby.22597&key=10.1177%2F0268355516639421) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=27075680) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000400098900001)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=32&publication_year=2017&pages=152-159&journal=Phlebology&author=AB+Halk&author=RJ+Damstra&title=First+Dutch+guidelines+on+lipedema+using+the+international+classification+of+functioning%2C+disability+and+health)

94. Warren AG, Janz BA, Borud LJ, Slavin SA. Evaluation and management of the fat leg syndrome. *Plast Reconstr Surg* 2007; **119**: 9e‐ 15e.

[Crossref](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=16&doi=10.1002%2Foby.22597&key=10.1097%2F01.prs.0000244909.82805.dc) [CAS](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=32&doi=10.1002%2Foby.22597&key=1%3ACAS%3A528%3ADC%252BD2sXptlKmsQ%253D%253D) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=17255648) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000207676700003)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=119&publication_year=2007&pages=9e-15e&journal=Plast+Reconstr+Surg&author=AG+Warren&author=BA+Janz&author=LJ+Borud&author=SA+Slavin&title=Evaluation+and+management+of+the+fat+leg+syndrome)

95. 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; **33**: 153‐ 162.

[Crossref](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=16&doi=10.1002%2Foby.22597&key=10.1007%2Fs00266-008-9214-y) [CAS](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=32&doi=10.1002%2Foby.22597&key=1%3ASTN%3A280%3ADC%252BD1M3it1eitw%253D%253D) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=18663515) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000264457400005)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=33&publication_year=2009&pages=153-162&journal=Aesthetic+Plast+Surg&author=JJ+Stutz&author=D+Krahl&title=Water+jet%E2%80%90assisted+liposuction+for+patients+with+lipoedema%3A+histologic+and+immunohistologic+analysis+of+the+aspirates+of+30+lipoedema+patients)

97. Wollina U, Heinig B. Treatment of lipedema by low‐volume micro‐cannular liposuction in tumescent anesthesia: results in 111 patients. *Dermatol Ther* 2019; **32**: e12820. doi:[10.1111/dth.12820](https://doi.org/10.1111/dth.12820)

[Wiley Online Library](https://onlinelibrary.wiley.com/doi/10.1111/dth.12820) [PubMed](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=8&doi=10.1002%2Foby.22597&key=30638291) [Web of Science®](https://onlinelibrary.wiley.com/servlet/linkout?suffix=null&dbid=128&doi=10.1002%2Foby.22597&key=000462941000025)[Google Scholar](http://scholar.google.com/scholar_lookup?hl=en&volume=32&publication_year=2019&pages=e12820&journal=Dermatol+Ther&author=U+Wollina&author=B+Heinig&title=Treatment+of+lipedema+by+low%E2%80%90volume+micro%E2%80%90cannular+liposuction+in+tumescent+anesthesia%3A+results+in+111+patients)

98. 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; **174**: 1061‐ 1067.

[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)

99. Peled AW, Slavin SA, Brorson H. Long‐term outcome after surgical treatment of lipedema. *Ann Plast Surg* 2012; **68**: 303‐ 307.

[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)

## Experimental/Investigational/Unproven Policies Short Version

This is one of the most common denial arguments. I have a list of the top-twenty denial reasons. This analysis includes 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 review 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.

## Top 20 Carrier Denial List

More detailed information is provided with the Excel spreadsheet on the website. Search for the “carrier denial” post.

1: E/I/U: Experimental/Investigational/Unproven

2: Cosmetic: This is strictly to improve appearance or aesthetics (avoid both terms!).

3: Not Medically Necessary: This is the same as not reconstructive. See notes for detail.

4: Conservative Measures: Conservative measures are good enough; case not made that they are not effective.

5: Lack Of Research: Lack of research to support the efficacy and safety of liposuction.

6: Patient is Obese: Patient is obese and simply needs to lose weight; obesity is not addressed adequately. A carrier could deny the surgery and state that the patient simply needs to lose weight.

7: Patient Too Sick: The patient is too sick for the operation (does not meet medical necessity).

8: Patient Normal Weight: Normal weight patients have a different set of issues. The photographs won't be as dramatic in regard to a malformed appearance. The insurance company may be inclined to want to wait and see how the disease progresses.

9: Expert Opinion Denial: Expert opinion by xyz doctor said it's not necessary

10: Liposuction Not Proven: liposuction not proven to be effective or provide long-term benefit; not proven to reduce need for conservative therapy.

11: Study Size: study sample size is small

12: Lipo Not Proven Effective: liposuction not proven effective.

13: Lipo Not Proven safe: liposuction not proven safe.

14: No Control Group: There are two issues here. One is the issue of a "double-blind" test. It is virtually impossible with liposuction. There is no way to double-blind a procedure that changes appearance. It is an unreasonable request. The other, more reasonable is to compare the sample of liposuction patients with a comparator group that had no surgery. While a reasonable request, I am not aware of a specific study with a specific comparator group.

15: Early Stage: Patient is in the early stages of lipedema and liposuction not necessary.

16: Expert Opinion Letter: (aka Letter Of Medical Necessity[LMN]). This explains the need for the liposuction surgery.

17: Medical Clearance Letter: The address that the patient is well enough to tolerate the procedure. I view this as different from the EOL or LMN above.

18: Co-Morbidities: Co-morbidities were not addressed properly and based on medical necessity (the patient may die) the procedure is denied.

19: Out Of Network: No in-network surgeon is available. This is not typically an approval issue but how much they will pay for an out-of-network surgeon. Contractually they are supposed to provide coverage for your condition.

20: General: Poor Documentation: Documentation in general is substandard or inadequate or does not support the premise that liposuction is necessary.

## Doctor Documentation Supporting Liposuction for Lipedema

As a medical record auditor I have reviewed over 10,000 medical records in my career. While not a doctor, I have researched hundreds of medical acronyms and medical diagnoses. My focus is slightly different from the physician. I am looking for statements that support the medical necessity for liposuction. All roads lead to that conclusion. In the progress notes I look for consistency, instances of cloning (not allowed), vague statements, and incomplete notes.

In regard to supporting liposuction for lipedema, all documentation sent to the insurance carrier must support that the surgery is reconstructive and medically necessary, all conservative measures have been exhausted and are ineffective in halting the progression of the disease—and the patient is well enough to tolerate the procedure.

That’s it in a nutshell. With everyone you speak to be sure to repeat that information over and over again. With every bit of documentation you collect and send, ask if it supports medical necessity.

To provide more insight into this issue I have assembled two additional documents. Both are Excel Spreadsheets.

First is my **Top Denial Reason List**. This is related to the Gotcha! list but focuses more on the top reasons carriers deny a claim (either pre-authorization or an appeal) and what you need to do about it. The takeaway is that some reasons are discrete and separate from one another.

**Denial Examples** include Experimental, Investigational or Unproven, conservative measures are sufficient (case not made that liposuction is necessary), and the patient is too sick for the procedure (a safety issue and often listed as a medical necessity denial). Those are all very different reasons and each requires a different strategy.

Second is a **Gotcha! list.** This is a list of gray areas, hurdles, and Catch-22 events that will trip up those new to the world of carrier reimbursement. I’ve been working with managers, coders, and billers for over 25 years and have been collecting a list of “gray areas” for years. These are reimbursement gold. Frustrating but gold.

## A Short Primer on Provider Documentation SOAP

**SOAP** is an acronym for Subjective, Objective, Assessment and Plan. More prevalent and obvious with paper claims, this organization is built into the structure of most Electronic Medical Record (EMR) systems. This may be considered to be old school, but it’s an important concept and does cause confusion.

The Chief Complaint, the Review of Systems (ROS), the History of the Present Illness and the Past Family and Social History are all part of the **Subjective Section**. Known as the History section, this is what the patient tells the Provider. The doctor asks questions and documents the answers.

The Exam is the **Objective Section**. This is what the Provider does; the exam must be performed by the doctor (although often in the real-world, technicians will take vitals and perform some tests).

As a case in point, the doctor might document pain in the history—as told by the patient, and again in the exam during the examination. In regard to documentation, as an auditor I would want to see it in *both places*. A reviewer could argue that listing pain in the history is “the patient’s opinion” whereas listing pain in the exam section is the Providers professional assessment. In addition I ask all Providers to give a quantitative status or level of the pain. Both issues are increase the strength of the documentation in making the case for liposuction.

**The Assessment**: (aka the Impression) is a discussion of what is wrong with the patient and something about it. The biggest omission here, in thousands of records I have reviewed, is that Providers simply list diagnoses here. That’s it—a list. They should also *always* document *something about the condition*, in particular its status: improving, worsening, stable, or not responding as expected to treatment. The best case is made when the patient is not responding as expected to treatment or worsening. No status information puts you at the mercy of the medical reviewer. It’s not a particular good case for reimbursement.

In terms of lipedema I would look for documentation confirming compliance with the treatment—signed by the Provider. The patient stating that they are compliant may be ignored by the insurance company. It is not legally binding. It could be hearsay or the patient’s opinion.

In addition, documentation should state that the condition will progress without further treatment and the only remaining treatment is liposuction. Also, the Provider could reference the three key components of reconstructive surgery: improve functionality, restore to normal appearance, and improve quality of life. The fourth is the patient is well enough for the procedure but that should go in a **Clearance for Surgery** document.

**Gotcha!** Even though the psychological ramifications of the surgery may be important, they are not necessary and many insurance companies explicitly state that psychological benefits do not support a procedure as reconstructive as opposed to cosmetic.

**Plan:** This would include notes for recommended treatments. Generally the effectiveness of the treatment would be addressed in the Assessment. The plan is where recommendations for conservative measures are documented and the conclusion that liposuction is the only remaining treatment.

## 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 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.
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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.
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## 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’s 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**.

1. Weight is gained disproportionately on hips, thighs and below knee (usually bilateral - affects both sides - and symmetrical - occurs evenly)
2. Larger bottom half and smaller waist
3. The feeling of fatty ‘nodules’ underneath the skin
4. Bruising occurs easily and is often unexplained
5. Legs are very sensitive to the touch
6. Deep throbbing/achy pain in legs
7. Pain in knee joints
8. Legs feel heavy and swell throughout the day (especially after long periods of standing or sitting)
9. Fat on legs is soft and looks dimpled like “orange peel skin“, legs may feel cold to the touch
10. Lipedema fat does not respond to dieting
11. Hands and feet are not affected
12. Skin of affected areas may be pale and cold
13. Upper arms may also be disproportionately fatter
14. Increased swelling in hot weather

If you can answer in the **affirmative more than 7 points**, it seems that 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 [DEC 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.

## Expert Opinion Letter Template

**Sample Medical Opinion 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.

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 document.

* IMPORTANT: I am not a doctor and the information below was gathered from multiple sources.
* This cut-and-paste document is to be used by *your* Provider as a template; these are suggestions only. Only use what is medically accurate and documented in the medical record.
* If it is not documented, it did not happen; reporting a procedure or diagnosis that is not documented could be construed as fraud.
* My notes are [in brackets]. Global search and replace names [Ms Moody] are also in brackets.
* The purpose of this template is to help your doctor think like a medical carrier reimbursement specialist–who is more interested in denying your claim as cosmetic, investigational, experimental or unproven. They may have never heard of lipedema or will immediately assume that liposuction is inherently a cosmetic procedure. That is not accurate. The may see the word “liposuction” and not read any further!
* Every word of your Expert Opinion Letter must demonstrate the procedure is reconstructive and medically necessary.

Jeffrey Restuccio, CPC, COC, MBA

Consultant

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**Sample Expert Opinion Letter (EOL) for Liposuction for Lipedema**

**Note:** some may also call this a **Letter of Medical Necessity (LMN).** It may also be included or part of a **Clearance for Surgery** letter but the focus of the clearance letter is to address pre-existing conditions, (co-morbidities) that may preclude the surgery. I would prefer that the Clearance letter be a separate document. The three most important safety issues to address are cardiovascular, obesity, and age.

DATE: September 7, 2020

From: [Dr. Adam Smith], Surgeon

RE: [Mabel Moody], D.O.B. 6-04-1970, SSN 123-45-6789

To Whom It May Concern:

My patient, Mabel Moody, has lipedema, [optional: stage 1/2/3\*] that limits her functionality, mobility, and gait; decreases her Quality of Life (constant pain), and, as a result of the condition, has created a malformed appearance.[the phrase “malformed” is a specific term used by Medicare so use it – Jeff]

Lipedema is a progressive, adipose tissue disorder with no known cure. It does not respond to diet or exercise.

**Photographs** of her condition are attached.

She is limited in Activities of Daily Living and is unable to work or exercise on a sustained basis. This diagnosis has been confirmed through physical examination and medical history.

Stemmer’s sign is negative [if taken] and other indications represent lipedema versus lymphedema.

An ultrasound is included [if taken] and confirms the diagnosis.

[Ms. Moody] was first diagnosed with lipedema on [July 31, 2010: INSERT DATE HERE].

[Ms. Moody]’s symptoms include:

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

If possible include an over-all quantitative pain and severity score such as EQ-5D VAS (Visual analogue scale). [Molina, 2019 study]

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.

General weakness.

Unstable walking or gait.

[Ms. Moody], as a result of her condition, has poor coordination.

In an 8-hour work day, [Ms. Moody] may [have the following symptoms / decrease in function/quality of life]:

[Ms. Moody] has undergone the following **conservative treatments**:

Manual Lymphatic Drainage (MLD); [list dates and outcome].

Combined decongestive therapy (CDT); [list dates and outcome].

Compression stocking care; [list dates and outcome].

[Ms. Moody] has been compliant with all treatments recommendations.

[Ms. Moody] has been compliant with a **weight-loss program** for her obesity as well as a [low-carbohydrate/Keto] diet regimen for both obesity and lipedema.

Her weight and BMI has decreased [xx percent], yet there has been little change in her malformed appearance, pain, functionality and quality of life. [This should also be documented in the managing physician’s progress notes].

I am enclosing all medical records, medical history, specific tests used, lab results, and relevant clinical findings.

A **Functional Capacity Exam** was performed on [insert date] and the results are:

An **ultrasound** was performed on [insert date] and the results are:

[Insert imaging test] was performed on [insert date] and the results are:

In my opinion, [Ms. Moody] is

Unable to resume any type of gainful employment due to physical impairment.

Her fatigue, pain, weakness, and other symptoms will significantly and consistently interfere with activities of daily living.

Without surgical intervention her condition will continue to worsen and potentially develop into lipolymphedema.

Lymph-sparing liposuction | tumescent liposuction | Water-Assisted liposuction [select one] is the only treatment, proven by research to be effective in improving function, reducing pain, and restoring the patient to a more normal appearance.

[Be sure to address in your letter (and all progress notes) these **four key components**:

1. Restore to normal appearance
2. Improve the patient’s functionality
3. Improve the patient’s Quality of Life (QOL)
4. The patient is well enough for the operation (Clearance for Surgery / address any and all co-morbidities)

**GOTCHA**! If you feel that I am repeating the four (4) components of reconstructive surgery a lot—I am. You, and your Provider, cannot repeat them enough. Why? Because it’s important to repeat and reinforce the notion that this surgery is ***not*** cosmetic and fits the official definition of reconstructive surgery. So, yes, I would like multiple Providers to include all four; I would like all cover letters and every conversation to include the list. If you contact the insurance company six times, you should repeat that the procedure is reconstructive, medically necessary and repeat that it meets the four components—every time.

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).

**[Clearance for Surgery Letter]**

I have evaluated the patient for comorbidities and her suitability for the procedure and ruled-out significant risk for:

Cardio-vascular issues

Obesity.

Diabetes, hypertension and hyperlipidemia

Her age

[I am not an expert on pre-operative evaluations. The issue here is to document all comorbidities, if they exist, and how they will be addressed during surgery. Comorbidities and the danger to the patient’s health are a specific reason requests for pre-authorization are denied.

**GOTCHA!** The denial reason will be “medical necessity” but note that its **safety** and not the **efficacy** of the procedure that is the issue. The denial reason is the same but the issue and the appeal argument are different.

Without treatment my expectation is that [Ms. Moody] will see a continued decline in function and mobility over time, lasting longer than 12 months.

“Liposuction is an effective treatment for lipedema and has a beneficial effect on net health outcomes based on clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.”

**[RESEARCH**: I have dozens of research paper references. The most succinct list is in the [Sample Request for Policy Evaluation Document](#_Sample_Request_for) in the Appendix. It has fifty research references. Not all fifty reference liposuction but it’s’ a start.]

Sincerely,

[Dr. Adam Smith]

\* There are three recognized lipedema stages (some research and numerous websites illustrate four; for more on this see our website: [www.lipoforlipedemareimbursement.com](http://www.lipoforlipedemareimbursement.com)).

**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. (1)

Diet and exercise won't reduce the fat involved in lipedema. But it's still important to do those things because they can help you lose weight from nonlipedema fat and reduce inflammation.\*\*[https://www.webmd.com/women/qa/can-diet-and-exercise-help-with-lipedema]

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 and prevent progression of the disease and expensive treatment. (Rapprich 2010)

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

References

1. Herbst, KL, Rare adipose disorders (RADs) masquerading as obesity, Journal List Acta Pharmacol Sinv.33(2); 2012 FebPMC4010336

\*\*Genetic and Rare Diseases Information Center: "Lipedema."

West Virginia University HealthCare: "Lymphedema."

Lymphology Association of North America: "What is Lipedema?"

UCDavis Health System: "Manual Lymphatic Drainage Massage (MLD)."

University of Rochester Medical Center: "Lymphedema Therapy: Complete Decongestive Therapy."

Lymph : "Understanding Lipedema."

Film Team: "The Disease They Call Fat."

## 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: This 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 [DEC 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 |
| 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 |

**Anthem Blue Cross Blue Shield** has a published E/I policy (2015) and a more current, *approval* 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.

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**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.

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**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.

\*\*\*

**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.

## 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.

## Sample Request for Policy Evaluation Document

This is **not** the entire document. It is just the introduction letter. The document is 15 pages with 50 research references. It is a concise document you can edit and send to your carrier. It contains a lot of the same information in this guidebook but in a different organization and format.

You can [download the document](https://12uh.com/lipoforlipedemareimbursement/request-for-reimbursement-policy-evaluation-for-liposuction-for-lipedema/) from the website or request the latest version from me.

Note the purpose is not for a case-by-case evaluation but a request for the medical insurance carrier to change their policy regarding liposuction for lipedema.

July 29 2020

Director of Medical Policy

Noridian Medicare

P.O. Box 39

Lawrence KS 66044

To: Director of Medical Policy

Subject: Reimbursement Policy for Liposuction for Lipedema

Introduction

This is a request for a Medical Policy evaluation in regard to reimbursement for liposuction for *lipedema*, a reconstructive and *medically necessary* procedure that is the only remaining treatment once all conservative treatment measures have been exhausted. This document is to help you establish a formal policy.

Using the Anthem Blue Cross/Blue Shield policy as a template and supported with fifty medical research papers, the following is a formal, revised policy that will help patients suffering from this progressive and debilitating disease.

The procedure has many names, including:

Tumescent Liposuction

Tumescent Local Anesthesia (TLA)

Microcannular Tumescent Liposuction[[7]](#endnote-7)

Lymph-Sparing Liposuction

Lymph-Sparing, Tumescent Liposuction[[8]](#endnote-8)

Water-Assisted Liposuction (WAL™)

Power-Assisted Liposuction (PAL™)

Laser-assisted Lipolysis (LAL)

Ultrasonic Liposuction (Vaser™)

In this document, to distinguish liposuction for lipedema from *cosmetic* liposuction, I will refer to the procedure as “lymph-sparing liposuction.” Providers may use any combination of the terms above including simply “liposuction.” This request will explain what lipedema is, recommended documentation requirements for liposuction reimbursement, and why lymph-sparing liposuction should be reimbursed.

I will make the case that lymph-sparing liposuction for lipedema is reconstructive, medically necessary and reimbursing this procedure would be advantageous to the patient and the insurance company. The procedure will slow the progression of lipedema, a progressive and debilitating condition, saving the insurance company thousands of dollars of care for a condition that has no cure and will only get worse without treatment.

The following four (4) components define a surgery as *reconstructive* and medically necessary (not cosmetic). The purpose of lymph-sparing liposuction is to:

1. Restore to a normal appearance.
2. Improve/restore function (mobility and gait).
3. Improve Quality Of Life (QOL). Address pain and bruising issues.
4. The patient is healthy enough for the procedure. (Comorbidities are addressed.)

These all meet the AMA™, American Society of Plastic Surgeons (ASPS), Medicare and Title XVIII Social Security Act requirements for a reconstructive surgical procedure. Per the Noridian Medicare Reconstructive LCD:

Reconstructive surgery is performed to restore bodily function or to correct a deformity resulting from disease, injury, trauma, birth defects, congenital anomalies, infections, burns or previous medical treatment, such as surgery or radiation therapy. Reconstructive surgery is reasonable and necessary when the purpose is to improve necessary functioning of a malformed body part whereas surgery addressing appearance alone is considered cosmetic and not covered.[[9]](#endnote-9)

Federal law, Section 1862(a)(1)(A) of Title XVIII of the Social Security Act reads:

Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, ***except*** as required for the prompt repair of accidental injury or **for improvement of the functioning of a malformed body member** [emphasis mine];[[10]](#endnote-10)

This document will prove, based on a wealth of research, that lymph-sparing liposuction is not experimental, investigational, or unproven (E/I/U). There are dozens of positive, peer-reviewed research studies on liposuction for lipedema documenting that the procedure is safe and effective both short and long-term. [[11]](#endnote-11)

Many Primary Care Physicians are unfamiliar with lipedema and misdiagnosis it. [[12]](#endnote-12) Many confuse it with edema, obesity, and lymphedema–all separate conditions. Due to the fact that there are few qualified surgeons for liposuction for lipedema, we also ask that you add an *out-of-network* waiver or exception.

Not *all* lipedema patients will be eligible for the surgery. As part of the pre-authorization package, it must be documented that conservative measures have been followed for at least six months, with limited results and that no other options are available to address the patient’s reduced functionality, lower quality of life, and pain. The patient must also be well enough for the procedure and all comorbidities–for instance heart problems–have been addressed. Research supports this:

“Implications of this new definition of liposuction [as reconstructive and medically necessary] should induce third-party public payers and insurance companies to reconsider their remuneration and reimbursement policies.”[[13]](#endnote-13)

Lymph-sparing liposuction meets and often exceeds the medical necessity requirements for other comparable procedures that *are* reimbursed such as breast reconstruction, cleft palate repair, and panniculectomy [tummy tuck] after bariatric surgery. Lipedema is a painful, disfiguring, and debilitating disease that impairs the patients’ ability to walk, exercise, and diminishes their quality of life. Without treatment it progresses into a malformed and disfiguring appearance that will impede the patient’s ability to even stand and walk. It meets not just one of the reconstructive criteria–it meets *all of them*. The procedures referenced above have all been historically denied as cosmetic at one time. Most are now reimbursed as reconstructive and medically necessary (some, like panniculectomy are reimbursed in the most egregious cases).

We are asking that you:

1. **Implement** a positive reimbursement policy for liposuction for lipedema, a misunderstood and under-diagnosed condition.
2. **Differentiate** between *reconstructive* liposuction for *lipedema* (lymph-sparing liposuction) and *cosmetic* liposuction in your policy manual.
3. **Designate** lymph-sparing liposuction as reconstructive and medically necessary given that the patient’s documentation meets medically necessary requirements as outlined in this policy review request.
4. Do not list liposuction singularly as cosmetic or liposuction for lipedema as an investigational or experimental or unproven procedure.

If you have any questions or need additional information you may reach me at (901) 517-1705 or by e-mail: [lipoforlipedemareimbursement@gmail.com](mailto:lipoforlipedemareimbursement@gmail.com). My mailing address is:

7204 Deventer Cove

Memphis TN 38133

Sincerely,

Jeffrey Restuccio, CPC, COC

Ritecode

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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## Gotcha! List for liposuction for lipedema

1: WHAT IS A GOTCHA! ?: A Gotcha List is a list of all the gray areas regarding reimbursement for liposuction for lipedema. These are issues where a simple Yes or No is not adequate. Most are very subjective. Most are open to interpretation. If you ask 10 consultants what the answer is you will get at least three answers (YES/NO/MAYBE). If they are certain of their answer--beware! Also included are Catch-22 issues where succeeding at one goal creates another problem.

2: PRE-AUTHORIZATION: Most surgeons will not apply for the pre-authorization without a scheduled surgery date and an up-front deposit. This is a unique situation to this surgery. A quick turnaround would be three-weeks. But some insurance carriers could take three-months to approve. The recomendation is to schedule the surgery out more than three weeks. Be sure to have all your photos and documentation before you plan the surgery--and know exactly who will send what and how they will send it (e.g., photos).

3: INCONSISTENT APPROVALS: Mary Sue, who just had surgery from the same doctor, was approved, yet yours was denied and everything looked about the same. Sometimes it matters who the insurance representative is. Some may just rubber stamp the claim, another may be in more of a denial mood. One claim may be approved with minimal documentation and another denied with everything perfect. Without an official policy you can expect inconsistent approvals and denials.

4: EASY OR HARD: Do you leave out documentation expecting the case to be easy and decide to include it only if you need to appeal? That is up to you. I prefer making your case the most compelling up-front.

5: WAIT!: Do not contact the insurance company for pre-authorization until you have all your documentation, where it is and who will send it and how. Example are photographs. (got it?).

6: TOO MUCH INFO !: Do I really need all this information? My strategy is the more information up front, the better; If the insurance company gets a sense you know your rights, the case is compelling, and know what you are doing, they will cave. If they get a sense they can deny the claim and avoid paying, they will.

7: MEDICAL NECESSITY: There are two versions of medical necessity. One is that the procedure is reconstructive and considered to be safe and effective. That encompasses several issues including E/I/U, co-morbidities, and the strength of the research proving its effective. The other is that the patient is too sick to tolerate the procedure. The denial reason will be the same but the appeal arguments are different and they address completely different issues.

8: FILE EVEN IF DENIED: Send whatever you have and can get. Remember that if the pre-authorization is denied, you must file anyway and be prepared for a fight with appeals.

9: ASSUME NOTHING: Don't assume anything is being done; check with everyone every week or two. Information gets lost all the time! The insurance company will often tell you they did not receive something you sent them. Don't worry about being pushy or a pest or repeating yourself. That is your job! Work on being extra nice and expect the runaound and account reps that don't want to be bothered with a complex case. It will be stressful. Focus on being relaxed and patient.

10: BE NICE BUT FIRM: Always get the name of everyone you speak with at the insurance company. Ask for e-mails; most insurance representatives won't give them out but try anyway.

11: PAYMENT UP-FRONT: Most surgeons require payment up-front before pre-authorization and approval even if they agree to assist with filing your claim. Some will require payment and a surgery date before they write you an Expert Opinion Letter. That is a Catch-22 because some pre-authorizations take months, not weeks.

12: NO FEE SCHEDULE: There are no fee schedules for liposuction surgery (reimbursement can be any amount; case by case). Medicare does not assign RVU's to the four liposuction CPT codes. This means that they are excluded from payment but that is not always the case as some single case reimbursements from Medicare have been reported. The Gotcha is that many surgeons don't want a Medicare fee schedule! The current private pay fee is much higher than what Medicare traditionally charges for similar procedures. The professional societies are not interested in lobbying for a reconstructive, lymph-sparing or tumescent liposuction for lipedema code. This is also a Catch-22 issue. Not being in the fee schedule is a problem but if there was an established fee schedule--must less than the going cash price, most surgeons may not accept it.

13: NOT CONTRACTED: Many liposuction for lipedema experts are not contracted with insurance companies and out-of-network. At best you can get an Singe Case Agreement or ask the insurance company pay you directly.

14: NORMAL WEIGHT: If you are a normal-weight patient, the insuror may request you wait for the surgery. Your photos may not be as dramatic. Emphasize pain and any impact on your ability to exercise and maintain your weight. In addition, you may need to reference research that illustrates that liposuction is effective at early stages.

15: MORBID OBESITY: Morbid obesity may be considered a co-morbidity and needs to be addressed. You could be at an advanced stage, a malformed appearance, with numerous functionality and Quality of Life Problems but too sick for the operation. That's a CATCH-22.

16: DENIAL REASON: Pay special attention to the denial reason. Some might say it's "cosmetic" others "not medically necessary" or it's "investigational, experimental or unproven." Each of those is related but slightly different.

17: TOO SICK: If the patient has an advanced stage, lipolymphedema, morbid obesity and has extremely limited functionality and mobility the reconstructive nature is strong but may be too sick to tolerate the procedure. That's Catch 22.

18: SINGLE CASE AGREEMENT: If your surgeon is out-of-network you may need to negotiate a Single Case Agreement (SCA). The SCA outlines the procedure, the number of treatments and payment amount. The carrier will pay the (non-contracted) clinic on a single-case basis. The Gotcha! is that your surgeon may not accept the SCA amount.

19: ADVOCATE OR NOT?: Should you pay for a reimbursement advocate? In Sep. 2020, the issue is that the time involved in obtaining payment can be moderate or extreme. Therefore it is difficult for an experienced Advocate to be able to work every aspect of the reimbursement process for a fair rate. Therefore you must assume as much responsibility as you can. See my Advocate question list on the website.

20: COVER LETTER: As the patient you can include a cover letter. It should read like a Table of Contents listing what you have provided. It is okay to include a short description of your condition but it should not substitute for Provider notes. If you don't have the Provider documentation I recommend, you can include the information in the cover letter but the insurance company may ignore it. While better than nothing, there is a danger that the ins. co. may question why the managing physician did not document that conservative measures were ineffective, for example.

21: DENIALS: Approvals and denials can take weeks, months or even years! Some ins. Co may approve in 3 weeks. Others may take months. Once denied, the review process may take many months; three to nine months. If there are multiple appeals the process could take longer than a year. Medicare has five official levels.

22: LIPEDEMA STAGES: Listing and focusing on the Lipedema stage. Some reimbursement consultants feel that listing the stage could cause a denial of the early stages. You are providing more specific information but it could hurt you if the carrier is inclined to deny the claim. That's a Catch-22.

23: NO ICD-10-CM Code: There is not a specific ICD-10-CM lipedema code. Most use R60.9 but it is simply listed as "Edema."

24: SIX MONTHS DOCO: Begin collecting Provider documentation 6 months or more in advance.

25: NOT BOARD-CERTIFIED: Many liposuction for lipedema experts are not not board-certified plastic surgeons.

26: NO EXPERIENCE: Many insurance companies recommend board-certified plastic surgeons, who perform relatively few liposuction for lipedema operations (as a percent of their total output). The agent does not understand the difference between cosmetic liposuction and reconstructive liposuction.

27: OUT-OF-NETWORK: Is the surgeon in network or out? (Most likely your surgeon is not contracted with the carrier and out-of-network).

28: CPT CODES: The four CPT codes are listed as "suction-assisted lipectomy" by body part. This is a very generic description and you will be making that case that your procedure is different from costmetic--which would use the same codes! This is a CATCH-22. If you make your case well enough that lymph-sparing, tumescent liposuction is different from generic suction-assisted or "cosmetic" liposuction the insurance company could determine the code is not appropriate and you will need to submit an unlisted CPT code for the procedure. This is done so it's not a dead end. You can still be reimbursed but it takes more effort to be reimbursed for an unlisted code.

29: IN-NETWORK SURGEON: The plan may recommend an in-network board-certified plastic surgeon with no lipedema experience. You might be approved but the insurance will assign the nearest in-network plastic surgeon assuming he/she can perform the surgery. Perhaps they list liposuction in their list of specialities. You will need to inform the carrier that liposuction for lipedema is a much more complicated, time-consuming procedure that requires specifica skills (lymph-sparing, tumescent liposuction) and experience (dozens and even hundreds of surgeries--specific to lipedema).

30: REQUEST EXCEPTION: Specifically request an "out-of-network" exception so they pay in-network fees.

31: NUMBER OF TX: Establish number of treatments (TX) and that the ins. co. will reimburse.

32: PHOTOS: Send Photos with pre-auth info. Determine how best to deliver them to the insurance company. The Gotcha is if you're normal weight or they are not very persuasive.

33: NOT SUCTION-ASSISTED LIPOSUCTION: The argument is that the procedure is not SAL but more complicated; if the insurance agent makes an issue of this (you cannot use the code and then argue that it’s not accurate or appropriate) and you cannot get around it, then you would need to use an unlisted CPT™ code: 38999 (unlisted procedure, hemic or lymphatic system). This creates more problems but is not unsurmountable.

34: LOGISTICS: Logistics with the surgeons office are a main hurdle. Many cosmetic surgeons are not contracted with any insurance companies. Many don't have practice management billing systems. You are on your own and the staff won't have the knowledge or experience to help you.

35: PATIENT FILE CLAIM: If clinic does not file the claim you will need to submit the insurance claim. If the ins. co. agrees to pay the clinic (per SCA), submit CMS-1500 form; patient pay is the CMS-1490 form.

36: SIX MONTHS DOCO: What to do if the surgery is scheduled and you don't have all your information? My inclination is if you don't have the basic documenation would be to postpone the surgery until you have your six months of conservative measures documented properly and most importantly--they were ineffective.

37: CONSERVATIVE MEASURES WERE SUCESSFULL: A catch-22 is when you have good Provider documentation stating that all conservative treatments have been followed but there are no status notes or the assessment was that the treatments were working as expected. If there is not sufficient documentation that the measures failed and the progression of the disease will worsen without surgical treatment the claim may be denied.

38: EXTERNAL REVIEW BOARD: Some ins. Co. will send your claim to an External Review Board. This may increase the approval time. Also some Review Boards are quick to deny the claim.

## Return on Investment

This is a “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.

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