Medical Necessity Guidelines: Surgical Treatments for Lymphedema and Lipedema

Effective: October 1, 2023

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

Yes ☒ No ☐

Applies to:

Commercial Products
☒ Harvard Pilgrim Health Care Commercial products; Fax 800-232-0816
☒ Tufts Health Plan Commercial products; Fax 617-972-9409
CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 857-304-6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 857-304-6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products
☐ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0965
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

Overview
Lymphedema is a chronic condition that develops over months to years due to a physiological imbalance of blood flow and lymphatic drainage and results in an accumulation of protein-rich fluid in the extremities. Lymphedema is classified into primary and secondary forms. Primary lymphedema refers to inherited causes in which females have a higher incidence. Secondary lymphedema is a result of damage or obliteration of the lymphatic system caused by either surgery, radiation therapy, infection, or trauma. Although lymphedema may be clinically apparent, imaging is required to confirm the diagnosis and to rule out other conditions. Conservative therapy is the mainstay of treatment comprised of manual lymph drainage, physical exercise, skin care, compression therapy and compression garments. When conservative therapy fails and lymphedema becomes chronic, refractory, and nonpitting, surgical methods may be medically necessary to improve lymphatic drainage, such as liposuction, lymphovenous bypass or lymph node transplant.

Clinical Guideline Coverage Criteria

Lipectomy or Liposuction
The plan considers liposuction (including suction-assisted protein lipectomy (SAPL), also referred to as suction lipectomy), as medically necessary for the treatment of lymphedema when ALL of the following criteria below are met.
1. Patient meets **All** of the following diagnostic criteria:
   a. A certified lymphedema therapist confirms a diagnosis of lymphedema by symptoms and findings and documents the Member has *International Society of Lymphology stage ≥ II lymphedema (ISL)*
   b. A diagnosis of lymphedema by **One** of the following diagnostic measurements:
      i. **Unilateral disease**
         1) Volumetry differential (circumferential measurements and/or perometry Differential) >10% for affected dominant extremity or >7% for affected non-dominant extremity; **or**
      ii. **Bilateral disease**
         1) Lymphoscintigraphy findings must show a minimum of a one-hour delayed transit time to first-level lymph nodes, axillary lymph nodes (upper extremity lymphedema) or inguinal lymph nodes (lower extremity lymphedema), or dermal back flow.

2. Patient meets **ALL** of the following criteria:
   a. Results of MRI imaging show moderate to severe fat hypertrophy
   b. **BMI ≤ 35g/m2**
   c. Failure to respond to at least 6 months of optimal conservative treatment including compression therapy with bandaging, garments, or gauntlet and any of the following therapies: lymphoedema-specific manual lymphatic drainage, skin care, physical therapy, and exercises for lymphedema
   d. There is documentation of **One** or more of the following:
      i. Pain or sense of heaviness or discomfort in the limb; **or**
      ii. Restricted range-of-motion and functional limitation (difficulty ambulating or performing activities of daily living); **or**
      iii. Recurrent episodes of infection/cellulitis
   e. The plan of care postoperatively is to continue to wear compression garments as instructed to maintain the benefits of surgery
3. Patient has **NONE** of the following:
   a. Active comorbid condition(s) that would impede healing (i.e., untreated, or uncontrolled cancer, venous occlusive disease, active infection of the extremity)
   b. Transient lymphedema
   c. Lipedema without lymphatic dysfunction
   d. Not compliant with wearing compression garments continuously and/or has not demonstrated the ability to tolerate compression therapy or physical therapy sessions
   e. Pregnancy
4. Planned surgery to be performed at a certified lymphedema center of excellence**

**Vascularized Lymph Node Transplant (VLNT)**

The plan considers lymph node transplant as medically necessary for the treatment of lymphedema when **All** of the following criteria below are met.

1. Patient meets **All** of the following diagnostic criteria:
   a. A certified lymphedema therapist confirms a diagnosis of lymphedema by symptoms and findings and documents the Member has *International Society of Lymphology stage ≥ II lymphedema (ISL)*
   b. A diagnosis of lymphedema by **One** of the following diagnostic measurements:
      i. **Unilateral disease**
         1) Volumetry differential (circumferential measurements and/or perometry Differential) >10% for affected dominant extremity or >7% for affected non-dominant extremity; **or**
         2) Lymphoscintigraphy shows at least a one-hour delayed transit time to first-level lymph nodes, axillary lymph nodes (upper extremity lymphedema) or inguinal lymph nodes (lower extremity lymphedema), or a dermal back flow pattern
      ii. **Bilateral disease**
         1) Lymphoscintigraphy shows at least one-hour delayed transit time to first-level lymph nodes, axillary lymph nodes (upper extremity lymphedema) or inguinal lymph nodes (lower extremity lymphedema), or a dermal back flow pattern

2. Patient meets **All** of the following criteria:
   a. **BMI ≤ 35g/m2**
   b. Failure to respond to at least 6 months of optimal conservative treatment including compression therapy with bandaging, garments, or gauntlet and any of the following therapies: lymphoedema-specific manual lymphatic drainage, skin care, physical therapy, and exercises for lymphedema
   c. There is documentation of **One** or more of the following:
      i. Pain or sense of heaviness or discomfort in the limb; **or**
ii. Restricted range-of-motion) and functional limitation (difficulty ambulating or performing activities of daily living); or
iii. Recurrent episodes of infection/cellulitis

d. The plan of care postoperatively is to continue to wear compression garments as instructed to maintain the benefits of surgery

3. Patient has **NONE** of the following:
a. Active comorbid condition(s) that would impede healing (i.e., untreated, or uncontrolled cancer, venous occlusive disease, active infection of the extremity)
b. Transient lymphedema
c. Lipedema without lymphatic dysfunction
d. Not compliant with wearing compression garments continuously and/or has not demonstrated the ability to tolerate compression therapy or physical therapy sessions
e. Pregnancy

4. Planned surgery to be performed at a certified lymphedema center of excellence**

**Lymphovenous Bypass**

The plan considers lymphovenous bypass as medically necessary for the treatment of lymphedema when all of the following criteria below are met.

1. Patient meets **All** of the following diagnostic criteria:
a. A certified lymphedema therapist confirms a diagnosis of lymphedema by symptoms and findings and documents the Member has *International Society of Lymphology stage ≥ I lymphedema (ISL)*
b. A diagnosis of lymphedema by **One** of the following diagnostic measurements:
   i. **Unilateral disease**
      1) Volumetry differential (circumferential measurements and/or perometry Differential) >10% for affected dominant extremity or >7% for affected non-dominant extremity, **or**
      2) Lymphoscintigraphy shows at least a one-hour delayed transit time to first-level lymph nodes, axillary lymph nodes (upper extremity lymphedema) or inguinal lymph nodes (lower extremity lymphedema), or a dermal back flow pattern
   ii. **Bilateral disease**
      1) Lymphoscintigraphy findings must show a minimum of a one-hour delayed transit time to first-level lymph nodes, axillary lymph nodes (upper extremity lymphedema) or inguinal lymph nodes (lower extremity lymphedema), or a dermal back flow pattern

2. Patient meets **All** of the following criteria:
a. BMI ≤ 35g/m2
b. Lymphatic channels present by ICG lymphangiography
c. Failure to respond to at least 6 months of optimal conservative treatment including compression therapy with bandaging, garments, or gauntlet and any of the following therapies: lymphoedema-specific manual lymphatic drainage, skin care, physical therapy, and exercises for lymphedema
d. There is documentation of **One** or more of the following:
   i. Pain or sense of heaviness or discomfort in the limb; **or**
   ii. Restricted range-of-motion and functional limitation (difficulty ambulating or performing activities of daily living); **or**
   iii. Recurrent episodes of infection/cellulitis
e. The plan of care postoperatively is to continue to wear compression garments as instructed to maintain the benefits of surgery

3. Patient has **NONE** of the following:
a. Active comorbid condition(s) that would impede healing (i.e., untreated, or uncontrolled cancer, venous occlusive disease, active infection of the extremity)
b. Transient lymphedema
c. Lipedema without lymphatic dysfunction
d. Not compliant with wearing compression garments continuously and/or has not demonstrated the ability to tolerate compression therapy or physical therapy sessions
e. Pregnancy

4. Planned surgery to be performed at a certified lymphedema center of excellence**
**Note:** Medical documentation must include all of the following: diagnosis, duration and onset of symptoms, relevant medical and surgical history including any history of prior infections and cellulitis, non-surgical treatment tried, level of functional impairment; specific procedure requested and treatment plan (inclusive of post-operative plan of care).

**Lymphedema Staging (International Society of Lymphology)**

**Description**

Stage 0 (subclinical) Swelling is not evident, and most patients are asymptomatic despite impaired lymphatic transport

Stage I (mild) Accumulation of fluid that subsides (usually within 24 hours) with limb elevation: soft edema that may pit, without evidence of dermal fibrosis

Stage II (moderate) Does not resolve with limb elevation alone; limb may no longer pit on examination

Stage III (severe) Lymphostatic elephantiasis; pitting can be absent; skin has trophic Changes

**The Lymphatic Education & Research Network (LE&RN) is a non-profit organization dedicated to education, research and advocacy related to lymphatic diseases (LD). For more information about the LE&RN international standards for best practice multi-disciplinary care in the management of LD and a listing of institutions designated as centers of excellence refer to: https://lymphaticnetwork.org/centers-of-excellence.**

**Limitations**

- Liposuction for lipedema will not be covered when performed for cosmetic purposes
- Immediate lymphatic reconstruction (e.g., Lymphatic Microsurgical Preventing Healing Approach [LYMPHA]) for prophylactic purposes) is considered investigational

**Codes**

The following code(s) require prior authorization:

**Table 1: CPT Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15832</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</td>
</tr>
<tr>
<td>15833</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy)</td>
</tr>
<tr>
<td>15836</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy)</td>
</tr>
<tr>
<td>15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</td>
</tr>
<tr>
<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
</tr>
<tr>
<td>15878</td>
<td>Suction assisted lipectomy; upper extremity</td>
</tr>
<tr>
<td>15879</td>
<td>Suction assisted lipectomy; lower extremity</td>
</tr>
<tr>
<td>38999</td>
<td>Unlisted procedure, hemic or lymphatic system.</td>
</tr>
</tbody>
</table>

The following ICD-10 diagnosis codes require prior authorization:

**Table 2: ICD-10 Codes**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I89.0</td>
<td>Lymphedema, not elsewhere classified</td>
</tr>
<tr>
<td>E65</td>
<td>Localized adiposity</td>
</tr>
<tr>
<td>E88.2</td>
<td>Lipomatosis, not elsewhere classified</td>
</tr>
<tr>
<td>Q82.0</td>
<td>Hereditary lymphedema</td>
</tr>
</tbody>
</table>

**References:**


Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.