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Insurance coverage for massive weight loss panniculectomy: a national survey and implications for policy

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Abstract

Background: Current panniculectomy coverage guidelines are developed by insurance companies, and surgeons have limited input as to what policies are fair to physicians and patients. In this study, for the first time, plastic surgeons were surveyed nationally to determine their opinions on which coverage criteria are clear, reasonable, and accessible.

Objectives: The objective of this study was to compare how frequently insurance companies use panniculectomy coverage criteria versus how favorably plastic surgeons assess these criteria.

Setting: United States plastic surgery practices.

Methods: Panniculectomy coverage criteria were compiled from third-party payors nationally. A survey using these criteria to assess the clarity, accessibility, and reasonability of each criterion was created and distributed to all members of the American Society of Plastic Surgeons.

Results: According to survey responses from plastic surgeons, the highest ranking criteria for panniculectomy coverage were "Patient is weight stable for at least 6 months" and "Patient must be at least 18 months post–bariatric surgery." These criteria were required by only 41.3% and 39.7% of insurance providers, respectively. The most common requirement for insurance coverage was "Chronic maceration of skin folds with failure to respond to at least 3 months of treatment with oral or topical medication." This was necessary for coverage by 81% of insurance providers, yet plastic surgeons ranked this criterion 12th of 17 criteria.

Conclusions: Here we present a physician assessment of insurance criteria for the coverage of panniculectomy. Given the discrepancy between how favorably a criterion is scored by plastic surgeons and how frequently it is required by third-party payors for coverage, we conclude that more physician involvement in the development of insurance coverage guidelines would be beneficial. (Surg Obes Relat Dis 2016;12:412–416.)

Keywords: Massive weight loss; Panniculectomy; Insurance; Accessibility; Body contouring

As the prevalence of obesity increases in the United States, the number of patients seeking bariatric surgery has increased exponentially [1–3]. After undergoing bariatric surgery, patients enjoy benefits such as weight loss, improvement in diabetes or hypertension, and reduction of joint pain. However, patients express dissatisfaction with the skin deformities that result from massive, rapid weight loss [4]. This excess skin can cause intertriginous rashes and irritation, difficulty with hygiene, limitations to mobility, and psychologic distress [5]. Therefore, many of these patients seek post–bariatric surgery body countouring to address these post–weight loss complications and to improve their functional and cosmetic outcomes. Up to 74% of patients desire to undergo body contouring surgery after gastric bypass. The most common of these procedures is

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panniculectomy, which 59% of patients seek after massive weight loss [4].

As the demand for body contouring surgery continues to rise, a major factor limiting patients' access to surgery is insurance coverage. Many patients who undergo bariatric surgery lack the financial resources to pay for subsequent body contouring procedures and, therefore, rely on third-party payors to cover their expenses [6]. Restrictions to coverage not only limit patients' access to body contouring procedures, but they also affect surgeons' compensation for office visits and procedures involving the massive weight loss population. Although these insurance policies have an important impact on plastic surgeons and their ability to care for a growing population, they are developed almost exclusively by the third-party payors with little to no physician input.

To better appraise plastic surgeons' opinions on these insurance policies that affect their practice, we—for the first time—created and collected survey data to assess the clarity, accessibility, and reasonability of existing insurance criteria for panniculectomy coverage. To our knowledge, no other studies have evaluated these guidelines and their influences on patient access to panniculectomy, the most common body contouring procedure [4].

Methods

Survey preparation

Insurance policies were collected from the third-party payors accounting for the largest market share: Highmark, Cigna, and Aetna. From these policies, a list of each distinct criterion was compiled, and this list was consolidated into more general summary criteria, which were subsequently included in the survey.

Three questions were developed to evaluate each criterion's clarity, accessibility, and reasonability (Fig. 1). Responses to each question were given as ratings on a 5-point Likert scale. Other data collected included each surgeon's practice type, setting, and geographic region and how many new patients the physician evaluates per month.

The survey was distributed to all members of the American Society of Plastic Surgeons (ASPS), and responses were collected during a period of 2 months.

Data analysis

Scores for clarity, accessibility, and reasonability were calculated for each criterion and were used to determine an overall rank. In addition, one-way analysis of variance was performed to determine whether surgeons from different practice settings varied in their rankings of clarity, accessibility, and reasonability. The same calculations were performed for practice type and geographic region. Student's t tests were used to determine whether surgeons evaluating fewer than 10 versus those with more than 10 new patients per month differed in their average scores for each of the 3 categories. Significance was set at a P value of .05.

How clear is the meaning of this criterion to you, the physician? (1 = unclear and 5 = clear)				
1	2	3	4	5
Of the massive weight loss patients you see, the percent who meet this criterion or could meet it with further treatment in the near term is closest to: (0%–100%)				
<5	25	50	75	100
Overall, how reasonable do you consider this criterion? (1 = unreasonable and 5 = reasonable)				
1	2	3	4	5

Fig. 1. Questions and scoring systems used for each criterion in the survey.

Results

Insurance criteria

Criteria were collected from 63 insurance plans. From these, 175 distinct criteria were compiled and used to generate 17 summary criteria that were included in the survey. These are listed in Table 1 by rank. Of these 17 criteria, surgeon-ranked no. 12 (chronic maceration of skin folds with failure to respond to 3 mo treatment) was most represented by insurance policies and was required by 51 plans (81%), whereas surgeon-ranked no. 6 (stable weight loss and body mass index [BMI] <35 kg/m^2) and surgeon-ranked no. 8 (pannus covers genitals and upper thigh crease) were required by only 1 insurance policy (1.6%).

The number of criteria required by each plan ranged from 1 (n = 14) to 9 (n = 1). States with the most restrictive plans (requiring that 8 to 9 criteria be fulfilled) were Kansas, North Carolina, South Dakota, and Vermont (Fig. 2). States with the least restrictive plans (requiring only 1 criterion to be fulfilled) were Arizona, Delaware, Washington D.C., Idaho, Maryland, New York, Oregon, Pennsylvania, Utah, Virginia, and Washington. California was the only state that offered both the most and least restrictive plans.

Survey results

Response. The survey was distributed to 7400 members of the ASPS. Responses were gathered from 450 surgeons (6.1%). All practice types, settings, and geographic locations were represented (Table 2). A majority of surgeons surveyed were in solo practice (n = 229; 50.9%), which is representative of the overall ASPS cohort [7].

Composite data. Overall, criteria ranged in clarity from a score of 3.47–4.84, with a mean of 4.14 (standard deviation [SD] = .39). The percent of patients who would meet each criterion ranged from 22.2% to 72.7%, with a mean of 48.9% (SD = 15%). Finally, the perceived reasonability of each criterion ranged from 2.17 to 4.21, with a mean of 3.22 (SD = .52).

The highest surgeon-ranked criterion overall was "weight-stable 6 months." This criterion was required by only 26 of 63 policies (41.3%) (see Table 1). Surgeon-ranked criterion no. 17 (low back pain without imaging