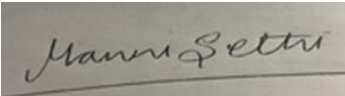


MCO Policy Submission

Policies submitted without this form will not be considered for review.

Plan: AmeriHealth Caritas Pennsylvania Community HealthChoices & Keystone First Community HealthChoices		Submission Date: 4/1/2026	
Policy Number: CCP.1554		Effective Date: 3/1/2026 Revision Date:	
Policy Name: Abdominoplasty			
Type of Submission:		Type of Policy:	
☒ New Policy	☒ Prior Authorization Policy		
☐ Revised Policy*	☐ Base Policy		
☐ Annual Review- no revisions	☐ Experimental/Investigational Policy		
	☐ Statewide PDL		
	☒ Other: Not Medically Necessary		
*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document. Please provide any clarifying information for the policy below:			
Name of Authorized Individual (Please type or print):		Signature of Authorized Individual:	
Manni Sethi, MD, MBA, CHCQM			

Abdominoplasty

Clinical Policy ID: CCP.1554

Recent review date: 2/28/2026

Next review date: 6/30/2027

Policy contains: Abdominoplasty.

Keystone First Community HealthChoices has developed clinical policies to assist with making coverage determinations. Keystone First Community HealthChoices' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by Keystone First Community HealthChoices, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Keystone First Community HealthChoices' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Keystone First Community HealthChoices' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First Community HealthChoices will update its clinical policies as necessary. Keystone First Community HealthChoices' clinical policies are not guarantees of payment.

Coverage policy

Abdominoplasty, defined as excision of excessive abdominal skin and subcutaneous tissue with umbilical transposition and fascial plication, is investigational/not clinically proven and, therefore, not medically necessary.

Alternative covered services

Nonsurgical management, including supervised physical therapy, core/pelvic floor exercises, supportive garments, and analgesics.

Background

Abdominoplasty, commonly known as a tummy tuck, is a surgical procedure that removes excess skin and fat from the abdomen and may involve tightening the abdominal wall through fascial plication with umbilical transposition. In coverage determinations, abdominoplasty is cosmetic when performed to improve abdominal contour or address residual skin laxity in the absence of objective abdominal wall dysfunction. Reconstructive abdominoplasty is limited to repair of clinically significant symptomatic rectus diastasis with documented functional impairment after failure of appropriate conservative management (Hernández-Granados, 2021).

A functional impairment is defined as a direct and measurable reduction in physical performance of an organ or body part, resulting in difficulties with physical and motor tasks, independent movement, or performing basic life functions. For rectus diastasis, functional impairment may include activity-limiting core instability attributable to abdominal wall dysfunction (Olsson, 2021).

Guidelines on management of rectus diastasis distinguish between cosmetic procedures and reconstructive surgery based on documented functional impairment and the failure of adequate conservative management. For symptomatic rectus diastasis, guidance recommends physiotherapy as first-line management; surgical repair is considered only after persistent symptoms and failure of conservative management with standardized documentation of the defect (Hernández-Granados, 2021; Carlstedt, 2021).

Findings

The evidence base addressing surgical repair of rectus diastasis derives predominantly from observational studies, systematic reviews, and consensus-based clinical practice guidelines. Randomized comparative data remain sparse, particularly for trials that directly compare surgical repair to prolonged conservative management or that isolate the functional contribution of rectus plication from concurrent soft-tissue procedures. Despite these constraints, the literature exhibits several consistent patterns: guidelines uniformly recommend structured conservative therapy as first-line management, systematic reviews consistently report improvements in patient-reported function and quality of life following surgical repair, and meta-analyses of conservative interventions demonstrate statistically significant but clinically modest reductions in inter-rectus distance. Most studies do not evaluate abdominoplasty as a single, standalone procedure. Instead, they evaluate repair of rectus diastasis, usually by linea alba or rectus plication, performed either during abdominoplasty or through other surgical approaches. Because plication is the core repair step across these approaches, that literature provides indirect but clinically relevant evidence when plication is performed for documented functional impairment.

Prevalence and persistence of rectus diastasis

Guidelines

Sperstad and colleagues, as cited in the Swedish national guidelines (Carlstedt, 2021), found a 60% prevalence of diastasis at 6 weeks postpartum gradually decreasing to 33% at 12 months, and de Oliveira and colleagues (2025) reported prevalence of 32.5% at 12 months. De Oliveira and colleagues (2025) noted that without intervention, diastasis recti abdominis can persist throughout life, leading to physical and emotional harm and potentially worsening in subsequent pregnancies. The Olsson (2021) review similarly reported that the prevalence for persisting rectus diastasis is approximately 30 to 40% of affected women. These data establish that rectus diastasis is not merely a transient postpartum finding but a condition that, in a substantial minority of women, persists beyond 12 months postpartum. Not all women with persistent diastasis experience functional impairment, but the condition is associated in a subset with functional disabilities including core instability, back pain, and abdominal deformations causing different degrees of functional and aesthetic disturbance (Olsson, 2021). The biomechanical rationale for treating this condition is grounded in the critical roles of support and stabilization provided by the abdominal wall: as de Oliveira and colleagues (2025) observed, it is essential to develop effective strategies for the proper management of diastasis recti abdominis given these biomechanical functions.

Three clinical practice guidelines address the management of rectus diastasis, and while they differ in scope, methodology, and specificity, they converge on several foundational principles. All three endorse conservative management as the appropriate first-line approach. The European Hernia Society guideline (Hernandez-Granados, 2021), developed using Grading of Recommendations, Assessment, Development and Evaluations methodology across nine key questions, concluded that physiotherapy appears to reduce inter-rectus distance but that no specific exercise regimen could be recommended; this was rated as a weak recommendation despite

moderate-quality evidence, the highest evidence rating in the entire guideline. The Swedish national guidelines (Carlstedt, 2021), developed using Oxford Centre for Evidence-Based Medicine levels of evidence, were more prescriptive, requiring at least 6 months of structured core training before surgery could be considered, graded at evidence level 2C. The American College of Obstetricians and Gynecologists Committee Opinion 804 (2020), recommended exercise before, during, and after pregnancy but did not address surgical intervention for diastasis.

The guidelines also share an emphasis on standardized measurement and documentation of diastasis. The European Hernia Society guideline defined rectus diastasis as a widening of the linea alba exceeding 2 centimeters, designating this as one of only two strong recommendations in the document, and proposed a new classification system based on width of separation, postpregnancy status, and presence of concomitant hernia (Hernandez-Granados, 2021). Both the European Hernia Society and Swedish guidelines recommend clinical examination as adequate for initial diagnosis, with ultrasound or calipers at 3 centimeters above the umbilicus for precise measurement and computed tomography reserved for detecting concomitant hernias (Hernandez-Granados, 2021; Carlstedt, 2021).

Where the guidelines diverge is in establishing thresholds for surgical intervention. The European Hernia Society defines rectus diastasis at 2 centimeters but does not specify a minimum width for surgical eligibility, instead recommending shared decision-making between patient and surgeon (Hernandez-Granados, 2021). The Swedish guidelines impose substantially more restrictive criteria: the largest width of diastasis should be at least 5 centimeters for surgical consideration, diastasis exceeding 3 centimeters may be considered only in the setting of pronounced bulging or within clinical trials, and at least 2 years must have elapsed since the last childbirth (Carlstedt, 2021). Both surgical guidelines identify linea alba plication as the recommended technique for isolated rectus diastasis without concomitant hernia, with the Swedish guidelines grading this at evidence level 1B based on good-quality randomized controlled trials (Carlstedt, 2021) and the European Hernia Society issuing a weak recommendation while declining to endorse any particular suture type or technique (Hernandez-Granados, 2021). For rectus diastasis with concomitant midline hernias, the European Hernia Society recommends mesh-based repair, noting that plication alone may suffice for hernias smaller than 1 centimeter (Hernandez-Granados, 2021). None of the three guidelines directly addresses the specific clinical scenario of abdominoplasty with plication performed for functional indications, and the American College of Obstetricians and Gynecologists (2020) does not discuss surgical intervention for diastasis at all. The overall quality of evidence underlying all three guidelines is limited: seven of nine European Hernia Society recommendations were weak, the Swedish guidelines acknowledged great regional variation and generally low evidence levels, and the American College of Obstetricians and Gynecologists document employed no formal evidence grading system.

Meta-analyses

Limitations of conservative therapy

The meta-analytic literature evaluating conservative interventions for rectus diastasis converges on a consistent finding: exercise-based therapies produce statistically significant but clinically modest reductions in inter-rectus distance that are unlikely to resolve symptomatic diastasis. The magnitude of this effect is remarkably stable across independent meta-analyses conducted by different research groups using different search strategies and inclusion criteria. Benjamin and colleagues (2023), analyzing six randomized controlled trials with 161 participants, found a pooled mean difference of negative 0.43 centimeters (95% confidence interval negative 0.82 to negative 0.05, I-squared 86%, moderate certainty); a sensitivity analysis excluding one high-risk-of-bias

trial yielded a mean difference of negative 0.29 centimeters (95% confidence interval negative 0.51 to negative 0.06, I-squared 46%, high certainty). Beamish and colleagues (2025), in the largest identified meta-analysis encompassing 65 studies with 21,334 participants, found a pooled mean difference of negative 0.52 centimeters from five randomized controlled trials with 173 participants (95% confidence interval negative 0.99 to negative 0.05, I-squared 91%, low certainty), with a sensitivity analysis restricted to exercise alone yielding negative 0.35 centimeters (95% confidence interval negative 0.59 to negative 0.10, I-squared 52%, moderate certainty). Gluppe and colleagues (2021) found a similar magnitude in two pilot trials with 30 participants (mean difference negative 0.63 centimeters, very low certainty). De Oliveira and colleagues (2025), the most recent and largest conservative-treatment meta-analysis with 34 randomized controlled trials and 1,548 participants, reported a mean difference of negative 6.82 millimeters for abdominal exercises versus no intervention, rated as very low certainty evidence. The convergence of these estimates, ranging from approximately 0.3 to 0.7 centimeters, against a diagnostic threshold of 2 centimeters or greater, suggests that exercise-based conservative therapy achieves limited anatomic correction. Whether this magnitude of reduction is clinically meaningful depends on baseline inter-rectus distance, symptom correlation, and measurement reliability, but for patients with established symptomatic diastasis well above the diagnostic threshold, pooled reductions of this size are unlikely to produce anatomic resolution.

Several meta-analyses have further characterized which conservative modalities produce the largest effects. De Oliveira and colleagues (2025) found through subgroup analysis that significant inter-rectus distance reduction occurred only with isotonic abdominal exercises (mean difference negative 3.78 millimeters) and not with isometric exercises, and that the most effective co-intervention was electrical stimulation (mean difference negative 4.43 millimeters). Benjamin and colleagues (2023) found no additional benefit from adding deep core strengthening exercises to standard abdominal exercise (mean difference negative 0.02 centimeters, low certainty) and no significant difference between abdominal exercise and abdominal binders (mean difference negative 1.02 centimeters, 95% confidence interval negative 2.35 to 0.30, very low certainty). These findings indicate that while some conservative modalities, particularly isotonic exercise combined with neuromuscular electrical stimulation, may produce somewhat larger effects than others, none of the studied conservative approaches demonstrates reliable anatomic resolution of established diastasis.

The biological plausibility of this ceiling effect has been addressed directly in the meta-analytic literature. Benjamin and colleagues (2023) questioned the rationale for using strengthening exercises to reduce inter-rectus distance, observing that diastasis involves the linea alba and associated connective tissue rather than contractile muscle, and that exercise durations of 6 to 12 weeks, typical of included trials, are insufficient to induce the collagen synthesis and connective tissue remodeling that would be required to narrow the gap. This observation is consistent with the finding across meta-analyses that exercise adherence was poorly monitored and averaged only 30% of prescribed sessions (Benjamin, 2023), further limiting the likelihood of connective tissue adaptation. De Oliveira and colleagues (2025) similarly rated all primary findings as very low certainty and called for well-designed randomized controlled trials with high methodological quality to confirm results.

The physiotherapy evidence within the Mommers (2017) systematic review, drawn from six studies with 100 postpartum women, further illustrates this ceiling. No study demonstrated reduction of inter-rectus distance in a relaxed state, which is the measurement condition under which diastasis is defined, and all studies that reported reduction measured it during muscle contraction.

The Emanuelsson randomized controlled trial, as reported across multiple sources in the included literature, is the only trial to have directly compared surgical repair to a structured conservative program. Participants with

diagnosed rectus diastasis combined with functional disabilities were randomized to operative repair or a 3-month structured training program. At the conclusion of the training program, 87% (n = 26 of 30) of participants in the physiotherapy arm were dissatisfied with the results and opted for surgical intervention (Mommers, 2017). The Gormley (2020) review, drawing on a different data reporting from the same trial, placed this crossover rate at 81.25% (26 of 32). Regardless of which denominator is used, this high rate of voluntary crossover demonstrates that even when participants complete a supervised training program, the majority find the functional result insufficient and elect to proceed to surgery.

Functional outcomes of abdominoplasty with plication

The largest prospective functional outcomes study of abdominoplasty with plication in the included evidence base is the Taylor (2018) multicenter study, in which nine private plastic surgery clinics in Australia enrolled 214 postpartum women undergoing abdominoplasty with rectus diastasis repair. Back pain, assessed with the Oswestry Disability Index, declined from 10.9 preoperatively to 1.58 at 6 months ($P < 0.001$), and urinary incontinence, assessed with the International Consultation on Incontinence Questionnaire, declined from a mean score of 6.22 to 1.60 ($P < 0.001$) (Olsson, 2021). Body mass index and the presence of an umbilical hernia were identified as predictors of preoperative back pain.

Temel and colleagues (2016), in a prospective cohort study of 40 women undergoing abdominoplasty with vertical rectus plication, enrolled participants on the basis of excess abdominal skin, rectus diastasis, and substantial weakness of the anterior abdominal wall. At 6 months, back and lumbar pain assessed with a Visual Analog Scale declined from 83.3 to 17.0 ($P < 0.001$), posture assessed by bidirectional radiography demonstrated significant improvement in thoracic kyphosis angle ($P < 0.001$), lumbar lordosis angle ($P < 0.001$), and lumbosacral angle ($P < 0.001$), depression assessed with the Beck Depression Inventory decreased significantly ($P < 0.001$), and quality of life assessed with the Nottingham Health Profile showed significant improvements in fatigue, pain, and sleep ($P < 0.001$) (Olsson, 2021; Gormley, 2020). This study is the only one in the included literature to demonstrate objectively measured postural improvement following abdominoplasty with plication, using radiographic vertebral column measurements rather than patient self-report alone.

The Olsson primary study (2019), a prospective cohort of 60 consecutive participants with diagnosed rectus diastasis exceeding 3 centimeters combined with training-resistant abdominal core instability symptoms, enrolled only individuals who had failed conservative management. At 1-year follow-up, 98% of participants (55 of 56 who completed follow-up) reported fewer functional problems, with total Disability Rating Index scores on average 79.1% lower than before surgery ($P < 0.001$) (Olsson, 2021; Gormley, 2020). Short Form 36 Health Survey scores, which were significantly below Swedish population norms preoperatively ($P < 0.003$), reached normative values in all subscales postoperatively except bodily pain, in which they scored higher than norms (Olsson, 2021). Urinary incontinence scores on the Urogenital Distress Inventory declined from a median of 5 to 2 ($P = 0.001$), and trunk muscle endurance improved significantly, with trunk stability and side plank performance increasing from a mean of 40 to 56 seconds ($P < 0.001$) (Olsson, 2021). This study used open suture repair rather than formal abdominoplasty.

These individual studies are corroborated by Whitaker and colleagues (2025), who conducted the first systematic review to evaluate the functional and psychological effects of surgical restoration specifically in postpartum women. The review, registered with the International Prospective Register of Systematic Reviews, included five studies with 498 participants assessed for physical outcomes and 314 participants assessed for psychological outcomes. All included studies focused on surgical repair of rectus diastasis and abdominoplasty, and all

received a "Good" risk of bias rating. The pooled analysis reflected a minimum of 85% reduction in back pain and urinary incontinence and a statistically significant reduction in trunk dysfunction, with improvements reported as sustained at 3 years postoperatively. Quality of life increased significantly across all assessed domains, with 99.5% of participants reporting positive change in self-esteem and 95.2% reporting improvement in sexual wellbeing at 6 months. The review concluded that these findings support postpartum abdominoplasty surgery being classified as reconstructive and not merely cosmetic. Whitaker and colleagues (2025) further noted that the Australian healthcare system has reintroduced publicly funded abdominoplasty for postpartum rectus diastasis following twin pregnancy, citing health equity concerns.

The Forester and Sadiq (2023) systematic review compared abdominoplasty to minimally invasive techniques for diastasis repair in postpartum women. Analyzing 12 studies, the review found no significant difference in reduction of pain or improvement of urinary stress incontinence between participants receiving abdominoplasty or minimally invasive repair ($P > 0.05$), and no significant difference in complication rates ($P > 0.05$). Among the minimally invasive approaches, the preaponeurotic endoscopic repair technique reported that lower back pain resolved in 80% of cases and stress urinary incontinence resolved in 89.5% of cases postoperatively. The equivalence of functional outcomes between abdominoplasty and purely structural repair procedures is consistent with the interpretation that the functional benefit of abdominoplasty derives primarily from its plication component rather than from skin or soft-tissue excision, though no trial has directly isolated this contribution in a symptomatic diastasis population. The review also identified abdominoplasty as the most common surgical method for treatment of rectus diastasis in clinical practice (Forester, 2023).

Two randomized controlled trials within the review compared abdominoplasty with rectus plication to abdominoplasty without plication. Staalesen and colleagues (2015) enrolled 96 participants who had undergone bariatric surgery, and Wilhelmsson and colleagues (2017) enrolled 125 participants planned for abdominoplasty due to excess skin. Neither trial found significant between-group differences in quality of life, physical function, or abdominal endurance measures ($P > 0.05$ for all primary outcomes) (Gormley, 2020). An important limitation is that neither trial enrolled participants on the basis of functional impairment from diastasis. Within the otherwise null results, the Wilhelmsson trial observed significant improvement in running capacity in the plication group (Disability Rating Index running scores declining from 36 to 8, $P = 0.04$) and a significant decrease in back muscle endurance in the non-plication group ($P = 0.02$) that was not observed in the plication group (Gormley, 2020; Olsson, 2021). Neither trial reported complication data. Gormley (2020)

The abdominal canister mechanism

The consistent finding across the surgical literature that repair of rectus diastasis improves urinary incontinence provides evidence that the functional benefit of plication operates through a biomechanical mechanism rather than through subjective satisfaction. All four studies assessing urinary incontinence within the Olsson (2021) review reported significant improvement: Incontinence Severity Index scores declined from 3.6 to 0.7, prevalence declined from 42% to 3%, Urogenital Distress Inventory median scores declined from 5 to 2, and International Consultation on Incontinence Questionnaire mean scores declined from 6.22 to 1.60. Olsson and colleagues (2021) proposed a specific mechanism: repair of the ventral abdominal wall possibly provides stability to all parts of the abdominal canister, including the pelvic floor, and that the abdominal canister is an integrated system of collaborating muscle groups. The improvement in pelvic floor function following abdominal wall repair, an effect not reported after physiotherapy alone (Olsson, 2021), suggests that surgical restoration of the linea alba addresses a structural deficit that conservative management cannot replicate.

Karunaratne and colleagues (2025), in the largest cumulative dataset on abdominoplasty and urinary incontinence encompassing 13 studies with 719 participants, found that the preoperative rate of urinary incontinence was 72.81% and the postoperative rate was 38.88%, representing a reduction of 46.60%. Of participants whose individual trajectories were reported, 54.98% improved, 35.17% remained the same, and 6.80% worsened. Rectus plication was performed in 91.31% of included participants, and the rate of previous pregnancy, when reported, was 93.20%. Mean follow-up was 26.92 months. The review recommended that surgeons consider routine screening for urinary incontinence in preoperative evaluation, noting that the functional urinary changes following abdominoplasty have been generally under-recognized (Karunaratne, 2025).

Respiratory findings are consistent with this mechanism: Manetti and colleagues (2021) reported a decrease in self-reported shortness of breath from 28% to 4% following laparoscopic rectus diastasis repair in 74 participants. The Gormley (2020) review drew an analogy to ventral hernia repair, noting that restoring muscular continuity has been shown to improve truncal strength and abdominal wall function. However, the biomechanics of diastasis repair during abdominoplasty have not been directly studied.

Durability of functional improvement after surgical repair

Low recurrence rates across the surgical literature support the durability of anatomic restoration after plication. Within the Mommers (2017) review, all four laparoscopic plication studies reported 0% recurrence at follow-up ranging from 6 to 24 months, and only one open plication study reported any recurrence at 4%. Nahabedian (2018) noted that two-layer plication with nonabsorbable suture achieved 0% recurrence at a mean of 81 months in 12 women, while one small series (al-Qattan, 1997, as cited in Nahabedian, 2018) reported recurrence in all 20 women after vertical sheath plication with absorbable suture limited to the defect alone, attributed to failure to address both horizontal and vertical components of laxity. These findings suggest that suture material and extent of repair influence long-term outcomes, though the recurrence rates reported in smaller case series should be interpreted with caution.

The longest randomized follow-up comes from the Swedenhammar (2020) follow-up of the Emanuelsson randomized controlled trial. At a mean of approximately 5 years, both operative groups (suture plication and mesh repair) showed significant improvement in all Short Form 36 Health Survey domains compared to preoperative scores, with no recurrences and no difference between groups (; Carlstedt, 2021). Pain had decreased significantly at the 5-year follow-up (Olsson, 2021). The only meta-analysis comparing surgical techniques, Wang D and colleagues (2025), pooled four studies with 253 participants and found no significant difference between mesh repair and suture plication for seroma, infection, recurrence, or difficulty performing physical activity (all $P > 0.05$, very low quality evidence).Gormley, 2020

The complication profile of surgical repair is consistent across reviews: Gormley (2020) reported an overall complication rate of 17.0% among 276 participants who received plication, with seroma, wound dehiscence, and minor bleeding as the most common events. Olsson (2021) reported seroma rates of 5 to 23%, hematoma rates of 2.7 to 6.7%, and surgical site infection rates of 3.3 to 5%.

Overarching patterns

Across the evidence base, several patterns warrant emphasis. The evidence consistently supports surgical repair of rectus diastasis as producing improvements in patient-reported functional outcomes, including back pain, urinary incontinence, respiratory symptoms, physical function, posture, and quality of life. These improvements appear to be durable, with low recurrence rates when appropriate plication technique is employed

and functional benefits maintained at 5-year follow-up in randomized data. Conservative management, while appropriate as a first-line approach and endorsed by all available guidelines, achieves anatomic effects that are statistically significant but clinically limited, and the only randomized trial comparing surgical to conservative management found that the large majority of participants in the conservative arm were dissatisfied and crossed over to surgical intervention.

Across systematic reviews, all five studies measuring back pain within the Olsson (2021) review demonstrated statistically significant improvement ($P < 0.001$ for all), and quality of life improved across all studies measuring it in both the Olsson (2021) and Gormley (2020) reviews. In contrast, objective measures of abdominal muscle strength have produced inconsistent results: two of three studies within the Gormley (2020) review demonstrated significant improvement, but one randomized controlled trial found no significant between-group difference in abdominal endurance.

The subset of studies that specifically used abdominoplasty as the operative approach demonstrates functional outcomes consistent with the broader rectus diastasis repair literature. Three recent systematic reviews each approach the question from a different angle: Whitaker and colleagues (2025) concluded that postpartum abdominoplasty surgery should be classified as reconstructive, Karunaratne and colleagues (2025) demonstrated a 46.60% reduction in urinary incontinence sustained over 26.92 months, and Forester and Sadiq (2023) found no significant difference in functional outcomes between abdominoplasty and minimally invasive diastasis repair.

References

On February 2, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Service Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “abdominoplasty,” “rectus diastasis,” and “diastasis recti.” We included the best available evidence, as per established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available), and professional guidelines informed by such evidence and clinical expertise.

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Policy updates

1/31/2026 initial review date and clinical policy effective date: 2/28/2026

Related Codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1554. This is not an exhaustive list of codes.

Code	Code Description
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy