Medical Coverage Policy

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Redundant Skin Surgery

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the

terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses surgical procedures for the excision of redundant or excessive skin and subcutaneous tissue involving the thigh (thigh lift/thighplasty), leg, hip, buttock, and arm (arm lift/brachioplasty), as well as rhytidectomy (facelift) procedures involving the forehead, neck, cheek, or chin.

Coverage Policy

Please refer to Coverage Policies for Panniculectomy and Abdominoplasty, and Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift for criteria relating to these surgical procedures. This policy is intended to address redundant skin surgery for anatomical areas not addressed in those Coverage Policies.

Coverage for redundant skin surgery varies across plans. Refer to the customer's benefit plan document for coverage details.

If coverage for the specific service is available, the following conditions of coverage apply.

Rhytidectomy, or procedures for excision of redundant or excessive skin of other anatomical areas (e.g., neck, upper and lower extremities, buttocks), is considered medically necessary when ALL of the following criteria are met:

- There is presence of a functional deficit due to a severe physical deformity or disfigurement resulting from the redundant or excessive skin.
- The surgery is expected to restore or improve the functional deficit.
- The redundant or excessive skin is demonstrated on preoperative photographs; for procedures involving sensitive anatomical areas (e.g., genital or buttock regions), documentation by the treating provider is sufficient and photographs are not required.
- The redundant or excessive skin is interfering with activities of daily living.

- For rhytidectomy (facelift), the individual must be a non-smoker or agree to abstain from all tobacco and nicotine products for at least three (3) weeks before and three (3) weeks after surgery.
- For areas other than the face, there is evidence of persistent intertriginous dermatitis, cellulitis, or skin ulceration that is refractory to at least three (3) months of medical management, including ALL of the following as applicable:
  - adequate hygiene practices
  - topical antifungals
  - topical and/or systemic corticosteroids
  - topical and/or systemic antibiotics
- When performed following significant weight loss, the individual must have maintained a stable weight for at least the preceding six (6) months and ONE of the following:
  - When weight loss is the result of bariatric surgery, at least eighteen (18) months have elapsed since surgery
  - When weight loss is associated with glucagon-like peptide-1 (GLP-1) agonist therapy (e.g., semaglutide), the individual has maintained a stable weight either while on therapy or following discontinuation of pharmacologic treatment, if applicable
  - For weight loss not associated with bariatric surgery or pharmacologic therapy, documentation by the treating provider demonstrates stable weight

Rhytidectomy, or procedures for excision of redundant or excessive skin of other anatomical areas (e.g., upper and lower extremities, buttocks), for ANY of the following is considered cosmetic and not medically necessary:

- The surgery is being performed to treat psychological symptomatology or psychosocial complaints, in the absence of significant physical, objective signs.
- The surgery is being performed for the primary purpose of improving appearance.
- The suction-assisted lipectomy is performed alone and not as part of another medically necessary procedure.

Labiaplasty (i.e., surgery performed to change the appearance or reduce the size of the labia) is considered cosmetic and not medically necessary. Please refer to the Coverage Policy Gender Dysphoria Treatment for information regarding labiaplasty procedure as part of gender reassignment surgery.

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15828	Rhytidectomy; cheek, chin, and neck

CPT®* Codes	Description
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy);arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839†	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

†**Note: Considered Cosmetic/Not Medically Necessary when used to report labiaplasty**

Suction-assisted lipectomy

Considered Cosmetic/Not Medically Necessary when performed alone and not as part of a medically necessary procedure:

CPT®* Codes	Description
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

Labiaplasty

Considered Cosmetic/Not Medically Necessary when used to report labiaplasty:

CPT®* Codes	Description
56620	Vulvectomy, simple; partial

General Background

Redundant or excessive skin is characterized by loss of elasticity with overhanging folds of skin and subcutaneous tissue, most commonly occurring after significant weight loss or as part of the normal aging process. Reductions in adipose tissue volume, weakening of connective tissue support, and age-related changes across skin and underlying soft-tissue layers contribute to skin laxity, thinning, and diminished tissue recoil. These changes may result in redundant tissue that is prone to chronic irritation, intertrigo, ulceration, or infection, and in more severe cases may lead to functional impairment such as limitations in mobility, difficulty with hygiene, and persistent inflammatory skin conditions within skin folds. Surgical management, commonly referred to as body contouring, is intended to remove redundant skin and associated subcutaneous tissue. Surgical procedures include contouring of the thigh (thighplasty), leg, hip, buttock, and arm

(brachioplasty), as well as rhytidectomy (facelift) procedures involving the forehead, neck, cheek, or chin. Distinguishing whether such procedures are performed to restore function or to improve appearance is central to their clinical classification. The American Medical Association defines reconstructive surgery as procedures performed on abnormal body structures caused by disease or other conditions and intended to improve function, whereas cosmetic surgery is performed on normal structures primarily to enhance appearance (Villegas-Alzate, 2025; Luthringer et al., 2024; Toy & Rubin, 2024; Warren, 2024; American Medical Association, 2023).

U.S. Food and Drug Administration (FDA)
The FDA does not regulate surgical procedures. Any medical devices, drugs, biologics, or tests used as a part of these procedures may be subject to FDA regulation.

Rhytidectomy
Rhytidectomy (facelift) is a surgical procedure developed to address age-related changes of the face and neck. Facial aging is a multifactorial process involving progressive changes across all tissue layers, including the skin, superficial and deep fat compartments, the superficial musculoaponeurotic system (SMAS), and underlying bone. These changes result in skin thinning, loss of elasticity, weakening of connective tissue support, and descent of soft tissues, which may manifest as wrinkles, lower facial sagging, and cervical skin folds (Mangat & Starkman, 2026; Gladstone & Shipp, 2024; Warren, 2024; Mendelson & Farhadieh, 2022). Obesity and significant weight loss may further contribute to excessive redundant skin and deep skin folds, particularly in the neck (Brodell & Dolohanty, 2025; Vakharia, 2024).

Management of facial and cervical skin laxity includes both surgical and nonsurgical approaches. Rhytidectomy techniques vary but generally involve elevation and repositioning of the skin and underlying soft tissues, with contemporary approaches often addressing deeper structures such as the superficial musculoaponeurotic system (SMAS) and platysma to achieve more durable outcomes than skin tightening alone. Reported complications include hematoma, nerve injury, infection, scarring, venous thromboembolism, and skin flap necrosis, with hematoma being the most frequently reported adverse event. Tobacco and nicotine exposure are consistently identified in the surgical literature as significant, modifiable risk factors for postoperative complications following rhytidectomy, particularly skin flap necrosis and delayed wound healing. Individuals with active tobacco use or uncontrolled hypertension demonstrate higher complication rates, whereas perioperative abstinence from tobacco and nicotine products has been shown to reduce surgical risk and improve healing outcomes (Mangat & Starkman, 2026; Gladstone & Shipp, 2024; Warren, 2024; Mendelson & Farhadieh, 2022).

Literature Review
The existing evidence on rhytidectomy consists largely of medical textbooks and a limited body of peer-reviewed literature, the majority of which comprises retrospective observational studies. Across the available sources, there is a paucity of evidence supporting rhytidectomy as a reconstructive procedure intended to address functional impairment. Rather, rhytidectomy is most commonly performed for aesthetic enhancement. While the evidence base is limited by a lack of high-quality prospective or comparative studies, published reviews suggest that rhytidectomy is generally associated with low reported complication rates, including a low incidence of serious adverse events such as permanent nerve injury, and is considered safe for improvement of facial and cervical skin laxity when performed by experienced surgeons (Mangat & Starkman, 2026; Fang & de la Torre, 2025; Gandra et al., 2025; Gladstone & Shipp, 2024; Warren, 2024; Mendelson & Farhadieh, 2022).

Professional Societies/Organizations
The **American Society of Plastic Surgeons (ASPS), American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS), American Academy of**

Otolaryngology–Head and Neck Surgery (AAO-HNS), and **American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS)** publish educational materials and guidance related to reconstructive and cosmetic surgical procedures within their respective specialties. A review of publicly available resources from these organizations did not identify formal guidelines or position statements addressing the surgical management of facial or cervical skin laxity, including rhytidectomy.

Body Contouring Procedures

Excision of redundant or excessive skin of the upper and lower extremities, hips, and buttocks (e.g., brachioplasty, thighplasty) is commonly described as body contouring and is most frequently performed after massive weight loss (often defined in clinical literature as substantial losses exceeding 50–100 lbs.), or with age-related loss of skin elasticity which can result in laxity of the skin and subcutaneous tissues. After significant loss of fat tissue, the structures that normally support the skin weaken, reducing the skin's ability to retract, resulting in thinner skin and deep, persistent folds. These dependent folds may cause mechanical and functional limitations; reported concerns include fatigue with arm elevation, difficulty fitting clothing, and, in some cases, axillary intertrigo, as well as lower-body deformity (e.g., descent/deflation of the thighs and buttocks, excess medial thigh skin) associated with discomfort or difficulty with ambulation or hygiene (Villegas-Alzate, 2025; Luthringer et al., 2024; Toy & Rubin, 2024).

In individuals with excessive or redundant skin, tissue of the thighs, buttocks, or arms may hang away from zones of adherence and descend significantly, increasing friction and moisture trapping in areas of skin-to-skin contact (Villegas-Alzate, 2025; Luthringer et al., 2024; Toy & Rubin, 2024). This environment predisposes to intertriginous dermatitis (intertrigo), characterized by erythema, maceration, pain, burning, and weeping in these areas, including folds that persist after weight loss. Standard management is primarily non-surgical and includes meticulous hygiene, moisture reduction, barrier protection, topical antifungal agents, topical or systemic corticosteroids when inflammation is present, and topical or systemic antibiotics when secondary infection occurs (Brodell & Dolohanty, 2025; Green, 2024; Vakharia, 2024).

When clinically indicated, surgical excision is intended to eliminate deep folds and thereby reduce friction, moisture retention, and mechanical obstruction that contribute to chronic inflammation and functional limitation. Excisional approaches are selected based on anatomic region and may include medial or vertical thigh lift techniques, circumferential lower-body contouring for combined thigh/hip/buttock laxity, and brachioplasty for excess arm tissue. Suction-assisted lipectomy (liposuction) is described as an adjunctive technique used in combination with excisional body contouring procedures to improve contour by addressing residual adipose tissue. Extremity contouring is frequently performed in combination with other reconstructive procedures, such as abdominoplasty and/or panniculectomy, because excess skin commonly involves contiguous regions. In the post-weight-loss setting, the abdomen, hips, buttocks, and thighs are often described as a functional unit, and combined or staged approaches may be required to adequately address redundant tissue associated with functional limitation, hygiene difficulty, and chronic inflammatory skin conditions (Villegas-Alzate, 2025; Luthringer et al., 2024; Toy & Rubin, 2024).

Given the extent of tissue excision and the risk for wound-related complications, appropriate timing of body contouring surgery is a critical determinant of safety and durability of outcomes. In the post-bariatric population, medical textbooks, expert consensus, and clinical outcome studies consistently emphasize that body contouring procedures should be performed only after weight loss is complete and stable, as surgery during periods of active weight change is associated with increased complication risk and early recurrence of tissue laxity. Adequate time following weight loss allows for metabolic stabilization and nutritional optimization, which are widely recognized as essential to support wound healing and reduce postoperative complications. Accordingly, commonly cited recommendations include maintenance of a stable weight for at least 3–6 months,

and 12–18 months following bariatric surgery, prior to body contouring procedures (Villegas-Alzate, 2025; Luthringer et al., 2024; Toy & Rubin, 2024).

More recent outcome data further support these principles. Observational analyses demonstrate that individuals who achieve a stable weight plateau prior to body contouring surgery experience significantly lower rates of postoperative complications, including seroma, infection, and hematoma, compared with those with unstable preoperative weight (approximately 19.5% versus 45.8%). Preoperative body mass index is also a key predictor of outcomes, with fewer complications reported among individuals with a BMI below 30 kg/m^2. In addition, emerging evidence suggests that individuals who discontinue pharmacologic weight-loss therapies, including glucagon-like peptide-1 (GLP-1) receptor agonists, may experience more rapid weight recurrence than is typically observed following bariatric surgery. This potential for early weight fluctuation represents an important consideration when evaluating surgical timing and reinforces the importance of sustained weight stabilization prior to body contouring procedures (Garbaccio et al., 2025).

Even when performed following appropriate weight stabilization and careful selection, body contouring procedures are associated with a recognized risk of postoperative complications. Potential adverse effects of body contouring procedures are generally wound-related and include seroma, hematoma, delayed wound healing, wound dehiscence, infection, and scarring. Temporary postoperative edema of the extremities is common, particularly after thigh-lifting procedures, while lymphedema is a rare but serious complication. Evidence specific to extremity contouring indicates post-bariatric thighplasty is associated with relatively high rates of wound-related complications and substantial variability in reported outcomes across techniques and study designs, emphasizing the need for careful patient selection and surgical planning (Susini et al., 2024). Further risks described in the literature include sensory changes, skin necrosis, thromboembolic events, and the potential need for staged or revision procedures due to recurrent laxity or wound complications, especially in individuals with higher BMI or when multiple procedures are performed concurrently (Luthringer et al., 2024; Toy & Rubin, 2024).

Literature Review
Across the available sources, body contouring surgery is often performed for aesthetic enhancement; however, the most consistent clinical evidence pertains to procedures performed in the context of massive weight loss. In this population, body contouring surgery performed after adequate weight stabilization demonstrates sustained improvements in health-related quality of life and functional outcomes (Dalaei et al., 2024; Toma et al., 2018). Long-term prospective cohort data show that individuals who undergo body contouring surgery after bariatric surgery experience durable improvements in physical, psychological, and social domains of quality of life, with benefits maintained for up to ten years and outcomes comparable to or exceeding population norms, whereas patients undergoing bariatric surgery alone demonstrate gradual decline over time (Dalaei et al., 2024). Observational analytic studies further suggest that body contouring surgery may be associated with improved long-term weight maintenance compared with bariatric surgery alone, although effects on obesity-related comorbidities are less clearly demonstrated (de Vries et al., 2020). Earlier systematic reviews and meta-analyses, while methodologically heterogeneous, consistently report improvements in physical functioning, psychological well-being, and social participation following removal of redundant tissue after massive weight loss, supporting clinical benefit (Toma et al., 2018; Gilmartin et al., 2016). Collectively, the evidence indicates that body contouring surgery, when performed following adequate weight stabilization, may address persistent functional impairment and quality of life limitations associated with excess skin after bariatric weight loss.

Garbaccio et al. (2025) conducted a systematic review of randomized controlled trials and prospective observational studies to evaluate weight loss stabilization and maintenance associated

with glucagon-like peptide-1 (GLP-1) receptor agonist therapy and to inform optimal timing of body contouring surgery following pharmacologic weight loss. The review was undertaken in recognition that postoperative weight fluctuations may compromise surgical outcomes and increase complication risk, and that the timeline to weight loss plateau following GLP-1 therapy is less clearly defined than after bariatric surgery. Twelve studies comprising 13,947 adult individuals met inclusion criteria. Mean participant age was 48.4 ± 13.0 years, and mean BMI ranged from 31.4 kg/m² to 40.1 kg/m². Studies included adult populations treated with oral or subcutaneous semaglutide for at least 24 weeks, primarily for overweight or obesity, with some cohorts including individuals with type 2 diabetes mellitus. Studies were excluded if they evaluated only dual-agonist therapies, included immunocompromised populations, or lacked sufficient quantitative data to assess weight change over time. Weight loss plateau was defined as a period of at least one month with <3% additional weight loss. Weight recurrence was defined as regaining at least 25% of weight lost relative to nadir weight, which was defined as the lowest recorded weight during the study period. Pooled results demonstrated that weight loss plateau occurred at approximately 53.0 ± 8.2 weeks of therapy, corresponding to a mean weight reduction of 16.0% ± 3.1%. Plateau weight differed minimally from greatest on-treatment weight loss (2.0% ± 0.7%) and end-of-treatment weight loss (1.0% ± 1.2%). Two studies assessed weight recurrence following discontinuation of GLP-1 receptor agonist therapy. Weight regain was observed as early as 12 weeks post-discontinuation, with individuals regaining approximately 63% to 74% of maximal on-treatment weight loss by 24 weeks. These findings contrast with bariatric surgery cohorts, in which weight regain is typically more gradual. The authors concluded that while weight stabilization following semaglutide therapy generally occurs after 8–12 months of treatment, the high magnitude and rapidity of weight recurrence following medication discontinuation warrant caution when considering body contouring surgery. Study limitations include the predominance of observational study designs, heterogeneity of study populations and indications, limited data on long-term weight maintenance following GLP-1 discontinuation, and the absence of direct evaluation of body contouring surgical outcomes.

Professional Societies/Organizations
American Society of Plastic Surgeons (ASPS): The American Society of Plastic Surgeons has published a Practice Parameter addressing the surgical treatment of skin redundancy following obesity or massive weight loss, including non-abdominal anatomical areas such as the upper arms and thighs. The guidance notes that procedures such as brachioplasty and thighplasty are most commonly performed for cosmetic or contouring purposes. However, ASPS recognizes that in severe cases, excessive skin of the upper arms or medial thighs may be associated with functional impairment and may be considered reconstructive. In the absence of severe deformity or functional abnormality, surgical treatment of skin redundancy in these areas is considered cosmetic (ASPS, 2017).

The **American Society for Metabolic and Bariatric Surgery (ASMBS), American Society for Dermatologic Surgery (ASDS),** and **American Academy of Dermatology (AAD)** publish guidance and educational materials related to metabolic and bariatric surgery, postoperative care, dermatologic surgery, skin disease, and cosmetic dermatologic procedures. A review of publicly available resources from ASMBS, ASDS, and AAD did not identify formal guidelines or position statements addressing surgical body contouring procedures or the management of redundant or excessive skin.

Labiaplasty
Labiaplasty, or labia reduction, is a surgical procedure that removes or reshapes labial tissue. The procedure may be performed for asymmetrical, enlarged, or hypertrophic labia minora and/or labia majora. In general, labiaplasty is performed for reduction of labia minora; however, the procedure may also involve labia majora. The procedure is generally cosmetic in nature and is performed to improve appearance. The diagnosis of labia minora hypertrophy is based on clinical

assessment of labial anatomy in the context of reported symptoms or functional concerns. There are no standard diagnostic criteria for labia minora hypertrophy. Clinicians generally use labial width measurements, defined as the medial-lateral axis of the labia minora when gently stretched to full width. There are no standards for normal labial width, and numerous anatomic variations are considered normal. A stretched labial width of greater than six cm is commonly described as consistent with hypertrophy. Enlarged or protuberant labial tissue may be congenital or acquired, including changes associated with aging or weight fluctuation. When enlargement is pronounced, it may be associated with discomfort during exercise, sexual activity, or the use of tight-fitting clothing, as well as hygiene challenges. Within urology and sexual-medicine literature, labiaplasty is categorized as a form of female genital cosmetic surgery, and available publications emphasize the absence of standardized nomenclature, diagnostic criteria, or validated functional outcome measures, as well as a lack of high-quality evidence supporting medical benefit, with requests for surgery commonly driven by cosmetic or psychosocial considerations rather than structural or developmental abnormality (Kojancic et al., 2026; Laufer & Reddy, 2025; Alter, 2024).

Vulvectomy is a surgical procedure involving partial or complete removal of vulvar tissue. A simple, complete vulvectomy includes removal of the labia majora, labia minora, and clitoris, while a simple, partial vulvectomy may involve removal of a portion of the labia majora and/or labia minora with or without involvement of the clitoris. Vulvectomy or partial vulvectomy may be performed for diagnostic or therapeutic management of benign, premalignant, or malignant vulvar conditions and is distinct from procedures performed to alter the appearance or reduce the size of the labia. Vulvar surgery performed for the primary purpose of cosmetic modification, including reduction of labial tissue in the absence of a pathologic indication, is considered cosmetic and not medically necessary (Cooper, 2025; Lester, 2024; Moroney, 2024).

Literature Review
Escandón et al. (2022) conducted a systematic review and meta-analysis evaluating surgical techniques, clinical outcomes, complication rates, and satisfaction associated with labia minoraplasty. The review included 46 studies encompassing 3804 individuals who underwent labia minora reduction using a range of surgical techniques, including de-epithelialization, edge resection, wedge resection, laser-assisted approaches, and composite reduction procedures. Included studies were original articles reporting outcomes among cisgender female individuals undergoing surgical labia minora reduction, while studies involving congenital or acquired genital abnormalities, review articles, and preclinical studies were excluded. Primary outcomes included pooled satisfaction rates and the incidence of surgical complications. Follow-up durations ranged from 1 week to 109 months, with 242 individuals (6.4 percent) reported as lost to follow-up. The pooled satisfaction rate was 99 percent (95 percent confidence interval, 97 to 99 percent), with substantial heterogeneity across studies (I^2 = 63.09 percent; $p<0.001$). Serious adverse events, including flap necrosis, dyspareunia, and the need for revision surgery (4.44 percent), were reported. Key limitations include the predominance of lower-quality observational studies, limited long-term follow-up, participant attrition, and reliance on subjective outcome measures.

Sorice-Virk et al. (2020) conducted a prospective, single-arm case series evaluating changes in symptomatology among women requesting labiaplasty. The study included 62 participants aged 17–61 years (54.8% parous; 45.2% nulliparous) who underwent either trim or wedge labiaplasty. Individuals who could not commit to a minimum 6-month follow-up because of distance were excluded. Participants completed preoperative and postoperative surveys assessing 11 physical and appearance-related symptoms. The primary outcomes consisted of 11 labia-related symptoms, predominantly appearance-focused (e.g., self-consciousness, perceived attractiveness, self-esteem, and visible outline in clothing or swimwear), with a smaller subset of functional symptoms also assessed (e.g., impacts on intimacy, twisting, and tugging). Follow-up ranged from 6 to 24 months (average 13.3 months). All participants reported at least one symptom preoperatively, with a mean of 6.5 symptoms. Postoperatively, 93.5 percent of participants were

symptom-free, with mean symptom counts decreasing to 0.23. All pre- to postoperative symptom changes were statistically significant ($p<0.001$). No major complications were reported. Study limitations include the absence of a control group, small sample size, restriction to a single practice in a single geographic area, reliance on non-validated survey instruments, lack of correlation between objective anatomical measurements and symptom severity, and limited follow-up duration with no data addressing long-term durability under conditions such as childbirth.

Professional Societies/Organizations
American College of Obstetricians and Gynecologists (ACOG): ACOG has issued guidance regarding cosmetic genital procedures, including labiaplasty. In its Committee Opinion on Elective Female Genital Cosmetic Surgery, ACOG states that procedures performed to alter sexual appearance or function, including labiaplasty, are not medically indicated, lack high-quality evidence supporting safety or effectiveness, and carry potential risks such as pain, bleeding, infection, scarring, altered sensation, dyspareunia, and need for reoperation. ACOG emphasizes that wide variation in external genital anatomy is normal and recommends patient education, counseling, and assessment for psychosocial factors, including body dysmorphic disorder, prior to considering surgical intervention. This Committee Opinion, originally published in 2020, was most recently reaffirmed in 2026, confirming that ACOG's position remains unchanged.

ACOG has also issued guidance specific to Breast and Labial Surgery in Adolescents, which emphasizes education and reassurance regarding normal anatomic variation, careful assessment of physical maturity and emotional readiness, and screening for psychosocial factors such as body dysmorphic disorder. ACOG cautions strongly against cosmetic genital surgery in individuals younger than 18 years and recommends that surgical intervention be reserved for rare cases involving significant congenital anomalies or persistent symptoms clearly attributable to anatomy. The opinion further highlights ethical and legal considerations, noting that surgical alteration of the labia that is not necessary to the health of an adolescent may violate federal and state laws (ACOG, 2017; updated 2020; reaffirmed 2024).

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Health disparities related specifically to conditions that result in redundant or excessive skin have not been well characterized in the peer-reviewed literature. Obesity remains a significant and growing public health concern in the United States. As of 2020, approximately 41.9% of U.S. adults met criteria for obesity, defined as a body mass index (BMI) greater than 30 kg/m², representing an increase from 30.5% of adults in 2000. The increasing prevalence of obesity has been accompanied by greater utilization of clinical weight-loss interventions, particularly bariatric surgery, which is widely recognized as the most effective intervention for achieving substantial and sustained weight loss in individuals with severe obesity. Case volumes of sleeve gastrectomy have increased approximately sixfold since 2011, reflecting growing demand for surgical weight-loss treatment pathways. Among individuals who undergo bariatric surgery, approximately

one in five subsequently undergoes body-contouring surgery, indicating that a subset of patients experience residual excess or redundant skin following significant weight reduction. More recently, the introduction of pharmacologic weight-loss therapies, including glucagon-like peptide-1 (GLP-1) receptor agonists, has further expanded treatment options for obesity and altered the landscape of weight-loss care. Public interest in medical weight-loss therapies has increased, with survey data indicating that nearly half of U.S. adults expressed interest in taking a prescription medication for weight loss. These evolving treatment pathways have contributed to a growing population of individuals who experience massive weight loss, which may be associated with excess or redundant skin (Garbaccio et al., 2025). Additional research is needed to better understand potential health disparities among individuals affected by these post–weight-loss conditions.

References

1. Alter GJ. Aesthetic genital surgery. In: Rubin JP, Matarasso A, eds. Plastic Surgery, Volume 2: Aesthetic Surgery. 5th ed. Philadelphia, PA: Elsevier; 2024. 926–950.

2. American College of Obstetricians and Gynecologists (ACOG), Committee Opinion. ACOG Committee Opinion No. 686 Summary: Breast and Labial Surgery in Adolescents. Obstet Gynecol. 2017 Jan;129(1):235. (reaffirmed 2024). Accessed Mar 26, 2026. Available at URL address: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/breast-and-labial-surgery-in-adolescents

3. American College of Obstetricians and Gynecologists (ACOG), Committee on Gynecologic Practice. ACOG Committee Opinion No. 795. Elective Female Genital Cosmetic Surgery. Jan 2020 (reaffirmed 2026). Accessed Mar 26, 2026. Available at URL address: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/elective-female-genital-cosmetic-surgery

4. American Medical Association. Definitions of "Cosmetic" and "Reconstructive" Surgery (Policy H-475.992). 2023. Accessed Mar 23, 2026. Available at: https://policysearch.ama-assn.org/policyfinder/detail/cosmetic

5. American Society of Plastic Surgeons (ASPS). Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. 2017 Jun. Accessed Mar 26, 2026. Available at URL address: https://www.plasticsurgery.org/documents/Health-Policy/Guidelines/guideline-2017-skin-redundancy.pdf

6. Brodell RT, Dolohanty LB. Intertrigo. In: UpToDate, Fowler J (Ed). Aug 19, 2025. UpToDate, Waltham, MA. Accessed Mar 20, 2026.

7. Cooper SM. Anogenital (non-venereal) diseases. In: Bolognia JL, Schaffer JV, Cerroni L, eds. Dermatology. 5th ed. Philadelphia, PA: Elsevier; 2025. 1255–1271.

8. Dalaei F, de Vries CEE, Poulsen L, Möller S, Kaur MN, Dijkhorst PJ, Thomsen JB, Hoogbergen M, Makarawung DJS, Mink van der Molen AB, Repo JP, Paul MA, Busch KH, Cogliandro A, Opyrchal J, Rose M, Juhl CB, Andries AM, Printzlau A, Støving RK, Klassen AF, Pusic AL, Sørensen JA. Body Contouring Surgery After Bariatric Surgery Improves Long-Term Health-Related Quality of Life and Satisfaction With Appearance: An International Longitudinal Cohort Study Using the BODY-Q. Ann Surg. 2024 Jun 1;279(6):1008-1017. doi: 10.1097/SLA.0000000000006244. Epub 2024 Feb 19. PMID: 38375665; PMCID: PMC11086676.

9. de Vries CEE, Kalff MC, van Praag EM, Florisson JMG, Ritt MJPF, van Veen RN, de Castro SMM. The Influence of Body Contouring Surgery on Weight Control and Comorbidities in Patients After Bariatric Surgery. Obes Surg. 2020 Mar;30(3):924-930. doi: 10.1007/s11695-019-04298-1. PMID: 31792701; PMCID: PMC7347702.

10. Escandón JM, Duarte-Bateman D, Bustos VP, Escandón L, Mantilla-Rivas E, Mascaro-Pankova A, Ciudad P, Langstein HN, Manrique OJ. Maximizing Safety and Optimizing Outcomes of Labiaplasty: A Systematic Review and Meta-Analysis. Plast Reconstr Surg. 2022 Oct 1;150(4):776e-788e. doi: 10.1097/PRS.0000000000009552. Epub 2022 Jul 26. PMID: 35877939.

11. Fang AH, de la Torre J. A Systematic Review of Rhytidectomy Complications and Prevention Methods: Evaluating the Trends. Ann Plast Surg. 2025 Jun 1;94(6S Suppl 4):S502-S516. doi: 10.1097/SAP.0000000000004272. PMID: 40459450.

12. Gandra G, Silva BS, Horta R. Facelift Surgery and Nerve Injury: A Systematic Review and Meta-Analysis. Aesthetic Plast Surg. 2025 Oct;49(20):5696-5711. doi: 10.1007/s00266-025-04932-7. Epub 2025 Jun 2. PMID: 40456989; PMCID: PMC12618380.

13. Garbaccio NC, Smith JE, Posso A, Schonebaum DI, Foster L, Cordero JJ, Foppiani J, Alvarez AH, Choudry U, Lin SJ. Plastic Surgery in the Ozempidemic: Considerations for the Timing of Body Contouring Surgery in Patients with Semaglutide-Associated Weight Loss. Aesthetic Plast Surg. 2025 Nov;49(21):6078-6088. doi: 10.1007/s00266-025-05112-3. Epub 2025 Aug 20. PMID: 40835770.

14. Gilmartin J, Bath-Hextall F, Maclean J, Stanton W, Soldin M. Quality of life among adults following bariatric and body contouring surgery: a systematic review. JBI Database System Rev Implement Rep. 2016 Nov;14(11):240-270. doi: 10.11124/JBISRIR-2016-003182. PMID: 27941519.

15. Gladstone HB, Shipp D. Preoperative assessment of the face, neck, and eyes. In: Khorasani H, Levit E, Dover JS, Alam M, eds. Procedures in Cosmetic Dermatology: Surgical Lifting. 1st ed. Philadelphia, PA: Elsevier; 2024. 16–38.

16. Green CB. Approach to the patient with an intertriginous skin disorder. In: UpToDate, Stratman E (Ed). Oct 14, 2024. UpToDate, Waltham, MA. Accessed Mar 20, 2026.

17. Hunter JG. Labia Minora, Labia Majora, and Clitoral Hood Alteration: Experience-Based Recommendations. Aesthet Surg J. 2016 Jan;36(1):71-9.

18. Knoedler L, Lellouch AG, Aguglia R, Sadati K, Knoedler S, Kehrer A, Cetrulo CL, Rendenbach C, Heiland M, Fenske J. Epidemiological and Economic Factors in Facelift Surgery in the USA: A Retrospective Multi-center Analysis. Aesthetic Plast Surg. 2026 Jan;50(1):18-26. doi: 10.1007/s00266-025-05221-z. Epub 2025 Sep 2. PMID: 40897962; PMCID: PMC12916513.

19. Kojancic E, Lai A, Raheem O, Acar O. Sexual function and dysfunction in the female. In: Dmochowski RR, Kavoussi LR, Peters CA, eds. Campbell-Walsh-Wein Urology. 13th ed. Philadelphia, PA: Elsevier; 2026. 1602–1633.e27.

20. Lamont J, Bajzak K, Bouchard C, Burnett M, Byers S, Cohen T, et al. No. 279-Female Sexual Health Consensus Clinical Guidelines. J Obstet Gynaecol Can. 2018 Jun;40(6):e451-e503.

21. Laufer MR, Reddy J. Labia minora hypertrophy. In: UpToDate, Sharp HT (Ed). Jul 29, 2025. UpToDate, Waltham, MA. Accessed Mar 26, 2026.

22. Lester S. Gynecologic and perinatal pathology. In: Lester S, ed. Manual of Surgical Pathology. 4th ed. Philadelphia, PA: Elsevier; 2024. 382–440.

23. Luthringer M, Shulzhenko NO, Capella JF. Upper limb contouring. In: Rubin JP, Matarasso A, eds. Plastic Surgery, Volume 2: Aesthetic Surgery. 5th ed. Philadelphia, PA: Elsevier; 2024. 878–890e.1.

24. Mangat DS, Starkman SJ. Rhytidectomy and facial liposuction. In: Francis HW, Haughey BH, Hill AT, Lesperance MM, Lund VJ, eds. Cummings Otolaryngology: Head and Neck Surgery. 8th ed. Philadelphia, PA: Elsevier; 2026. 386–403.e1.

25. Mendelson B, Farhadieh RD. Facelift. In: Farhadieh RD, Bulstrode NW, Mehara BJ, Cugno S, eds. Plastic Surgery: Principles and Practice. 1st ed. Philadelphia, PA: Elsevier; 2022. 1030–1040.

26. Moroney JW. Radical vulvectomy. In: UpToDate, Goff B (Ed). Oct 28, 2024. UpToDate, Waltham, MA. Accessed Mar 26, 2026.

27. Sorice-Virk S, Li AY, Canales FL, Furnas HJ. Comparison of Patient Symptomatology before and after Labiaplasty. Plast Reconstr Surg. 2020 Sep;146(3):526-536. doi: 10.1097/PRS.0000000000007081. PMID: 32842103.

28. Susini P, Marcaccini G, Cuomo R, Grimaldi L, Nisi G. Thighs lift in the post-bariatric patient - A systematic review. J Plast Reconstr Aesthet Surg. 2024 Nov;98:357-372. doi: 10.1016/j.bjps.2024.09.011. Epub 2024 Sep 10. PMID: 39341177.

29. Toma T, Harling L, Athanasiou T, Darzi A, Ashrafian H. Does Body Contouring After Bariatric Weight Loss Enhance Quality of Life? A Systematic Review of QOL Studies. Obes Surg. 2018 Oct;28(10):3333-3341. doi: 10.1007/s11695-018-3323-8. PMID: 30069862; PMCID: PMC6153583.

30. Toy JW, Rubin JP. Post-bariatric reconstruction. In: Rubin JP, Matarasso A, eds. Plastic Surgery, Volume 2: Aesthetic Surgery. 5th ed. Philadelphia, PA: Elsevier; 2024. 898–918.

31. Vakharia P. Intertrigo. Medscape. Updated Aug 2, 2024. Accessed Mar 24, 2026. Available at: https://emedicine.medscape.com/article/1087691-overview

32. Villegas-Alzate FJ. TULUA Abdominoplasty in Postbariatric Patients. In: TULUA Abdominoplasty. 1st ed. Philadelphia, PA: Elsevier; 2025. 188–198.

33. Warren RJ. Principles and surgical approaches of facelift. In: Rubin JP, Matarasso A, eds. Plastic Surgery, Volume 2: Aesthetic Surgery. 5th ed. Philadelphia, PA: Elsevier; 2024. 149–150.

Revision Details

Effective 9/15/2026

Type of Revision	Summary of Changes	Date
Annual Review	• Revise the medically necessary policy statement regarding preoperative photographs to remove requirement for sensitive anatomical areas. • Revise the medically necessary policy statement regarding rhytidectomy to include criteria that the individual is a non-smoker or agree to abstain from all tobacco and nicotine products. • Revise the formatting of the medically necessary policy statement regarding persistent intertriginous dermatitis, cellulitis, or skin ulceration. • Revise the formatting of the medically necessary policy statement regarding procedures performed following significant weight loss. • Revise the medically necessary policy statement regarding procedures performed following significant weight loss to include criteria for weight loss is associated with glucagon-like peptide-1 (GLP-1) agonist therapy. • Remove policy statement regarding cosmetic procedure: surgery for glabellar frown lines. • Revise policy statement regarding labiaplasty to include description as well as updated title of related Coverage Policy for Gender Dysphoria Treatment.	6/15/2026
Annual Review	• No clinical policy statement changes.	6/15/2025
Annual Review	• No clinical policy statement changes.	6/15/2024