


MEDICAL POLICY STATEMENT		
Effective Date	Next Annual Review Date	Last Review / Revision Date
10/11/2004	7/2012	7/2011
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CSMG Medical Policy Statements are derived from literature based and supported clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services are those health care services or supplies which are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative and are not provided mainly for the convenience of the member or provider.

A. SUBJECT

Keloid Repair

B. BACKGROUND

This document is to establish a policy to review the medical necessity for Keloid Repair.

Keloid formation is the overgrowth of fibroblastic tissue that arises usually in an area of injury, more frequently in African Americans. The lesion is usually treated with corticosteroid injections but may require surgical or laser excision. Reoccurrence of Keloid may require additional treatment options.

C. POLICY

For Special Needs Plan members, reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD).

Caresource considers Keloid repair medically necessary when formation has occurred after a surgical procedure and/or trauma and results in functional impairment as a result of its growth and/or location. All other Keloid repairs are considered cosmetic and **not** medically necessary and will not be covered. All requested corrective options will be reviewed for medical necessary.

For Medicare NCD: CMS Publication 100-02, Medicare National Coverage Determinations, Chapter 16, Section 120

<http://www.cms.gov/manuals/Downloads/bp102c16.pdf>

D. REVIEW / REVISION HISTORY

Date Issued: 10/11/2004

Date Revised: 7/10/2007, 7/2008

Date Reviewed: 7/1/2009, 7/2011

E. REFERENCES

1. McClean K, Hanke CW. The medical necessity for treatment of port-wine stains. *Dermatol Surg.* 1997; 23(8):663-667.
2. Hoeyberghs JL. Fortnightly review: Cosmetic surgery. *BMJ.* 1999; 318(7182):512-516.
3. Barnaby JW, Styles AR, Cockerell CR. Actinic keratoses. Differential diagnosis and treatment. *Drugs Aging.* 1997; 11(3):186-205.

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.