MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
10/11/2014	07/15/2016	07/14/2015

Policy Name	Policy Number
Keloid Repair	MM-0021

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that 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. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

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. DEFINITIONS

N/A

D. POLICY

CareSource considers Keloid repair medically necessary when formation has occurred after a surgical procedure and/or trauma 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 necessity.

For Medicare Plan members NCD: CMS Publication 100-02, Medicare National Coverage Determinations, Chapter 16, Section 120,
http://www.cms.gov/manuals/Downloads/bp102c16.pdf

If there is no NCD or LCD present, reference the CareSource Policy for coverage.

CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued:	10/11/2004
Date Reviewed:	10/11/2004, 07/10/2007, 07/10/2008, 07/01/2009, 07/15/2011, 07/15/2012, 07/15/2013, 07/15/2014, 07/14/2015
Date Revised:	07/10/2007, 07/10/2008

G. 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.
4. Al-Attar A, Mess S, Thomassen JM et al (2006) Keloid pathogenesis and treatment. Plast Reconstr Surg 117:286–300
5. Bock O, Schmid-Ott G, Malewski P et al (2006) Quality of life of patients with keloid and hypertrophic scarring. Arch Dermatol Res 297:433–438
6. Williams FN, Herndon DN, Branski LK. Where we stand with human hypertrophic and keloid scar models. Exp Dermatol. 2014 Jul 18.
7. **MCG, 19th Ed, 2015.**

This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

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