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, 

   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 Revised: 07/10/2007, 07/10/2008

G. REFERENCES

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.