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1.0 Description of the Procedure, Product, or Service

A keloid is a sharply elevated, irregularly shaped progressively enlarging scar due to excessive formation or growth during the healing process.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

The excision of keloids is covered for either of the following:

- a. Local irritation and/or rapid increase in size of the keloid; **OR**
- b. An inflammatory epidermal cyst where a sinus drainage exists.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

Excision or treatment of keloids is not covered in the following situations:

- a. When done solely for cosmetic purposes
- b. When keloids resulted from previously performed cosmetic procedures (breast augmentation, ear piercing, tattooing, etc.)

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for treatment of keloids.
- b. A letter of medical necessity signed and dated by the surgeon is required prior to rendering the surgery
- c. Documentation must include:
 1. Recipient demographics: Name, Address, NCHC ID, Date of Birth
 2. Location and size of the lesion
 3. Cause of the lesion
 4. Pre-operative photographs

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

When the claim with a diagnosis of 701.4 contains a procedure code for surgical excision and prior approval has not been granted, NCHC denies the claim.

C. Procedure Code(s)

Refer to the diagnosis code in **B** above.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Outpatient Hospital, ASC and Office

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.