To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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1.0 Description of the Procedure, Product, or Service

Keloid and hypertrophic scars are the results of dermal tissue following skin injury. They require no treatment unless they cause a functional impairment.

1.1 Definitions

Keloid scars

Keloids occur when the body continues to produce tough, fibrous protein known as collagen after a wound has healed. Keloids are often darker in color than the surrounding skin and may grow beyond the edges of a wound or incision. Keloids may recur (sometimes larger than before) after they have been removed.

Hypertrophic scars

Hypertrophic scars grow within the limits of the wound or incision. These scars often improve on their own without treatment but sometimes the improvement is not complete.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when 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 beneficiary'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 statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover Keloid Excision and Scar Revisions when the beneficiary meets the following specific criteria:

a. Impairment of communication, respiration, eating, swallowing or vision is caused by a scar or keloid; **or**

b. Obstruction of an orifice or bodily distortion that limits the performance of activities of daily living; **and**

c. the beneficiary's condition is expected to improve with the keloid excision or scar revision; **and**

d. Medical necessity may also be considered when there is evidence of pain, infection, drainage, or a rapid increase in size. Additionally, there has not been a favorable response to documented conservative treatment measures, such as steroid injection or pressure application.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:
a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover Keloid Excision and Scar Revision when:
a. the procedure is performed for cosmetic reasons only; or
b. the condition does not meet the criteria in **Subsection 3.2.1.**

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Keloid Excision and Scar Revision. The provider shall obtain prior approval before rendering Keloid Excision and Scar Revision.

Note: Please refer to Attachment A, Letter B. for billing requirements.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:
a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

In addition to the above, the provider shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:
a. Preoperative photographs of keloid(s) or scar(s) clearly marked with:
   1. the beneficiary's first and last name;
   2. the beneficiary's identification number;
   3. the provider's name and NPI; and
   4. the date the photograph(s) were taken;
b. Location and size of keloid(s) or scar(s);
c. Medical record documentation of evidence of pain, infection, and drainage;
d. Increase in size or significant physical functional impairment that limits normal physical functioning; and

e. Medical record documentation of any previous treatment and outcomes, including previous related surgery.

5.3 Additional Limitations or Requirements

None Apply.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1974

Revision Information:

Date	Section Revised	Change
08/01/2008	Throughout	Initial promulgation of a new Medicaid policy
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/12/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1-O-3 under Session Law 2011-145 § 10.41.(b)
03/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2012	Attachment A B. Diagnosis Codes	Added "Medicaid and to "NCHC denies the claim."
10/01/2012	Throughout	Replaced "recipient" with "beneficiary."
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
07/01/2018	Section 1.0	Updated the text.
07/01/2018	Subsection 1.1	Added definitions for keloid scars and hypertrophic scars.
07/01/2018	Subsection 3.2.1	Updated text.
07/01/2018	Subsection 5.2.2	Under a. more clarification for the photographs was added.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
01/03/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
01/03/2020	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
01/15/2023	Attachment A, Letter C	Removed CPT 13150 as this code is end-dated. Identified six CPT codes on this list as an add-on code by including + before the CPT code.

Date	Section Revised	Change
06/01/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.
12/15/2023		Fixed minor formatting issue; posting and amended date not changed.
10/01/2024	Subsection 3.2.1.a.	Removed the word "significant". Moved the list for readability. Removed "and/or" and replaced with "or."
10/01/2024	Subsection 4.2.1. a. and b.	Updated text to remove a list that was not inclusive. Removed the "Note regarding "significant physical functional impairment…"
10/01/2024	Subsection 5.1	Inserted text: "**Note:** Please refer to Attachment A, Letter B. for billing requirements."
10/01/2024	Attachment A, Letter B	Clarified text to add **NOTE:** Prior approval for keloid excisions and scar revisions must include one of the specified diagnosis codes in the table below as the primary diagnosis. Claims submitted without these required diagnosis codes will be denied by Medicaid. Removed L11.1, L55.9 and L56.0 from the ICD-10-CM Code table to align with edits in NC Tracks. Added Primary and Diagnosis to the title for this table. Removed CM from the title of the ICD-10-table to add Procedure to align with the ICD-10- procedure codes listed.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

NOTE: Prior approval for keloid excisions and scar revisions must include one of the specified diagnosis codes in the table below as the primary diagnosis. Claims submitted without these required diagnoses codes will be denied by Medicaid.

Primary ICD-10-CM Diagnosis Code(s)
L90.5
L91.0

ICD-10-Procedure Code(s)	
0HN0XZZ	0HNDXZZ
0HN1XZZ	0HNEXZZ
0HN4XZZ	0HNFXZZ
0HN5XZZ	0HNGXZZ
0HN6XZZ	0HNHXZZ
0HN7XZZ	0HNJXZZ
0HN8XZZ	0HNKXZZ
0HN9XZZ	0HNLXZZ
0HNAXZZ	0HNMXZZ
0HNBXZZ	0HNNXZZ
0HNCXZZ	

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of

service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Providers shall bill applicable revenue codes.

CPT Code(s)			
11400	12031	12057	14040
11401	12032	13100	14041
11402	12034	13101	14060
11403	12035	+13102	14061
11404	12036	13120	14301
11406	12037	13121	+14302
11420	12041	+13122	15100
11421	12042	13131	+15101
11422	12044	13132	15120
11423	12045	+13133	+15121
11424	12046	13151	15200
11426	12047	13152	+15201
11440	12051	+13153	15220
11441	12052	14000	+15221
11442	12053	14001	15240
11443	12054	14020	+15241
11444	12055	14021	15260
11446	12056		+15261
The plus sign (+) denotes an add-on code.			

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

The provider shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital, Office, Clinic, Ambulatory Surgery Center.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/