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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 – These 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 and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC 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.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

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

b. <u>NCHC</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: http://dma.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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 and NCHC 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 both Medicaid and NCHC

1. Medicaid and NCHC shall cover keloid excision or scar revisions if documentation in the medical record indicates significant functional impairment that limits normal functioning and the treatment can be reasonably expected to improve the impairment.

   "Significant physical functional impairment," may include, but is not limited to:

   a. Problems with communication;
   b. Problems with respiration;
   c. Problems with eating;
   d. Problems with swallowing;

e. Visual impairments;
f. Distortion of nearby body parts; and
g. Obstruction of an orifice.

2. Medical necessity may also be considered when there is evidence of pain, infection, drainage, and/or rapid increase in size; and there has been no favorable response to documented conservative treatment measures, such as steroid injection or pressure application.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC 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 and NCHC 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 both Medicaid and NCHC

Medicaid and NCHC shall not cover keloid excision and scar revision when:

a. performed to improve appearance, and not primarily to restore bodily function or to correct a significant deformity caused by congenital or developmental anomalies, accidental injury, disease, or growth and development; or
b. the beneficiary previously had this procedure and it failed.

Note: "Significant physical functional impairment" excludes social, emotional, and psychological impairments or potential impairments.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent

to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

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 and NCHC shall require prior approval for keloid excision and scar revision. The provider shall obtain prior approval before rendering keloid excision and scar revision.

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 or NCHC 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 DMA'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.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

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.

When the claim with one of these diagnoses contains a procedure code for surgical excision and prior approval has not been granted, Medicaid and NCHC deny the claim.

ICD-10-CM Code(s)	
L11.1	L90.5
L55.9	L91.0
L56.0	

ICD-10-CM 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	13150	15200
11426	12047	13151	+15201
11440	12051	13152	15220
11441	12052	13153	+15221
11442	12053	14000	15240
11443	12054	14001	+15241
11444	12055	14020	15260
11446	12056	14021	+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, Attachment 4.18-A, page 1, located at http://dma.ncdhhs.gov/.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

Providers shall bill their usual and customary charges.
For a schedule of rates, see: http://www.ncdhhs.gov/dma/fee/