

Document ID#: 1035212
Subject: Scar Revision
Effective Date: December 15, 2009

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	LPN

Note: Background, product, and disclaimer information is located at the end of this document.

Overview

A scar, for the purpose of this document, is a mark left in the skin by the healing of a wound, sore, or injury because of the replacement by connective tissue of the injured tissues. Scars result from wounds that have healed, lesions of diseases, or surgical operations (Taber's, 1993).

A keloid scar is a type of scar that can be red, raised, and puckered. It can often be darker in color than the surrounding skin. Keloid scars are caused by an excess production of collagen after a wound has healed (American Society of Plastic Surgeons, 2004).

Coverage Guidelines

Tufts Health Plan may pay for reconstructive scar revision when one or more of the following criteria are met:

- The scar interferes with normal bodily function, such as the movement of a joint or the restriction of a normal area of movement.
- The scar is associated with symptoms of pain, burning, or itching that cannot be effectively treated with both non-narcotic analgesics and steroid injections.
- The scar is unstable and has a history of intermittent breakdown.

Limitations

Tufts Health Plan will not pay for scar revision done for cosmetic purposes, for example: only to alter the appearance of the scar.

Codes

The following CPT codes require prior authorization:

Code	Description
11950	Subcutaneous injection of filling material (eg, collagen) 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen) 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen) 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen) over 10.0 cc
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)
77401 ¹	Radiation treatment delivery, superficial and/or ortho voltage

References

1. Taber's Cyclopedic Medical Dictionary. 17th edition. F.A. Davis Company. Philadelphia. 1993; 1756.
2. American Society of Plastic Surgeons. Surgical treatment for scars. Retrieved on April 4, 2004 from: http://www.plasticsurgery.org/public_education/procedures/

Approval History

Reviewed by the Clinical Coverage Criteria Committee in May 2003.

Subsequent Endorsement Date(s) and Changes Made:

- May 5, 2003: New criteria.
- June 28, 2004: Format revised. Additional clarification added to the Clinical Coverage Criteria, symptomatic scars defined.
- August 19, 2005: Reviewed and renewed without changes.
- October 2, 2006: Reviewed and renewed without changes.
- October 1, 2007: Reviewed and renewed without changes.
- October 1, 2008: On March 26, 2008, coding changes were approved at Medical Specialty Policy Advisory Committee: Plastic and Reconstructive Surgery meeting. CPT code 77401 was added to the list of codes that require Prior Authorization.
- May 4, 2009: Reviewed and renewed without changes.
- December 15, 2009: Additional clarification to treatment with steroids and non-analgesics narcotic.

¹ This CPT code requires Prior Authorization when done for diagnosis 701.4: Keloid scar, cheloid, hypertrophic scar, keloid.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.