



CIGNA MEDICAL COVERAGE POLICY

This Coverage Policy should NOT be used for Great-West benefit plans.

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| Effective Date | 4/15/2009 |
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| Coverage Policy Number | 0328 |

Subject Scar Revision

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Hyperlink to Related Coverage Policies

Acne Procedures
Breast Reconstruction Following
Mastectomy or Lumpectomy

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2009 CIGNA

Coverage Policy

Coverage for scar revision is dependent upon benefit plan language, may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit and may be governed by state or federal mandates. Under many benefit plans, scar revision is not covered when performed solely for the purpose of improving or altering appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one's appearance. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage.

Revision of scar tissue performed as part of reconstructive surgical revision of a breast on which a mastectomy/lumpectomy was performed is covered. Please refer to the Coverage Policy, Breast Reconstruction Following Mastectomy or Lumpectomy, for specific coverage criteria.

If coverage for scar revision is available, the following conditions of coverage apply.

CIGNA covers scar revision as medically necessary when the scar in question is documented to be causing a functional impairment (e.g., restricted movement) or is symptomatic (e.g., painful, ulcerated, inflamed, pruritic, prior infections) and ANY of the following treatment modalities are utilized as either monotherapy or combination therapy:

- compression/pressure therapy
- intralesional corticosteroid injections, with or without 5-fluorouracil
- laser therapy
- radiation

- silicone gel sheeting
- skin grafting/flap surgery
- surgical excision

CIGNA does not cover ANY of the following intralesional injectable medications for scar revision, because they are considered experimental, investigational or unproven for this use:

- bleomycin injections
- interferon therapy
- verapamil hydrochloride

CIGNA does not cover EITHER of the following because they are considered cosmetic and not medically necessary:

- scar revision when performed solely to improve physical appearance
- any of the following modalities of treatment for scar revision (this list may not be all-inclusive):
 - chemical peels
 - collagen injections and fat transfers
 - cryosurgery
 - dermabrasion
 - punch grafts

General Background

When cutaneous injuries occur, several healing processes take place in the skin. In most cases, wound healing (e.g., surgical or traumatic) results in repaired skin that does not create a functional impairment. However, some patients develop suboptimal healing responses and resultant scar formation, which may compromise physiological function or result in symptoms such as pain and itching. While scars may be considered a natural part of the healing process associated with cutaneous injuries, they often have decreased tensile strengths and permanent textural irregularities because of disturbed collagen production. Scar formation is affected by the patient's age and location of injury (American Academy of Dermatology [AAD], 2004); in addition, it may result from excessive wound tension, improper surgical repair, delayed re-epithelialization and a history of radiation to the affected area (Lupton and Alster, 2002). Scar tissue may also result from therapeutic procedures, and, in some cases, less than optimal results have been reported. Abnormal scarring is also noted commonly in some specific body locations, such as anterior chest, shoulders and scapula, and in darker-skinned persons. Scars that do not result in a functional impairment do not require any intervention; treatment would be considered cosmetic in nature and not medically necessary.

Hypertrophic scars, keloids and contractures are examples of suboptimal tissue healing that may result in impaired function and/or symptoms. Hypertrophic scars remain within the borders of the original incision or area of trauma. They appear as raised, red and nodular areas of tissue, occurring more commonly in areas subject to increased tension or movement or in areas with slow wound healing. The hypertrophic scar may be associated with itching and dysesthesias. Most hypertrophic scars spontaneously involute.

Keloids are similar to hypertrophic scars; however, they are bulkier and extend beyond the borders of the original site of injury. They appear as nodules that can be painful, itchy and disfiguring. Keloids are most often found on the earlobe, the shoulder and over the anterior chest and upper back area. Keloid formation may result in pain, pruritus, hyperpigmentation and disfigurement (Porter, 2002). In rare cases, keloids may become infected or ulcerate, and, in severe cases, the bulk of the tumor or, rarely, the contraction of the scar, may actually restrict movement (Shaffer, et al., 2002).

Contractures are the most severe form of a scar and usually occur as a result of the loss of a large area of skin. This type of scar is commonly found in patients who have experienced burn injuries. Contractures form when the full-thickness edges of skin overlying a joint pull together, affecting the underlying tissues, resulting in constriction of normal movement. Correcting contractures involves excising the scar and replacing it with additional tissue (i.e., graft or flap) or redirecting the tension lines with techniques such as W-plasty or Z-plasty.

Other classifications of scars include striae distensae (i.e., stretch marks), atrophic scars that result from an acute inflammatory reaction such as acne, and pigmented scars that result from excessive pigment deposition following injury. Treatment of these types of scars is generally aimed at improving physical appearance and is considered a cosmetic therapy, since they typically do not result in functional impairment.

Established Therapies

Depending on the severity of the scar, revision may aid in the restoration of function, as well as improvement of physical appearance. Several techniques have been employed to minimize scar tissue with proven success, although an optimal treatment method has not been established. In most cases, combination therapies seem to provide fewer recurrences, particularly for the treatment of keloids. Standard methods that are effective for the revision of scar tissue include silicone gel sheeting; compression therapy; radiation; surgical excision; dermabrasion; laser resurfacing with pulsed-dye laser; collagen injections and fat transfers; punch grafts and punch excision; chemical peels; cortisone injections; and cryosurgery (American Society of Plastic Surgeons [ASPS], 2005; AAD, 2004; Mustoe, et al., 2002). Silicone gel sheeting, also known as hydrocolloid dressing, has been effective in reducing scar thickness and pain, although reported results are variable. Compression therapy is utilized to flatten scars. Radiation used as monotherapy or combined with surgery is also efficacious for treating hypertrophic scars and keloids. Surgical excision removes the bulk of the scar and has the potential to improve the appearance with a thinner scar. When employed as a sole treatment for keloids, it has been associated with a high rate of recurrence; when employed with intralesional steroids, the recurrence rate appears to be lower than with surgery alone. Dermabrasion removes the upper layer of skin and is typically recommended for minor scarring. Other treatments, such as collagen injections and fat transfers, have been used to elevate indented scar tissue. Punch grafts may be used to provide a smoother skin surface for deep or pitted scars. Chemical peels involve the use of a chemical to remove the top layer of skin in order to improve appearance of superficial scars. Cortisone injections have been employed to reduce itching and improve pain associated with scar tissue. Cryosurgery involves freezing the upper layer of skin, possibly resulting in decreased size of scar formation. More involved surgical revision may include skin grafting and flap surgery. While their cosmetic results may be less than optimal, grafts and flaps may greatly improve the function of scarred areas.

Laser therapy has become a widely utilized treatment for scar revision. High-energy light is used to remove the damaged skin. Several lasers are available to treat scar tissue, including the pulsed-dye laser, the carbon dioxide laser and the neodymium: yttrium-aluminum-garnet (Nd:YAG) laser. Authors report lasers such as the continuous-wave argon, Nd: YAG and carbon dioxide laser, when used for revision of scars, have resulted in a high incidence of recurrent scarring, dyspigmentation and pain (Shaffer, et al., 2002; Mustoe, et al., 2002). Currently, these lasers are not widely used for the treatment of scars.

The current laser of choice for treating a hypertrophic and/or keloid scar is the vascular-specific pulsed-dye laser (Alster, 2007) and has been recognized as a first-line treatment option (Atiyeh, 2007). Research studies confirm that the newer pulsed-dye laser has been effective primarily in reducing erythematous color and, in some cases, in flattening and decreasing the bulk of scar tissue with minimal adverse effects (Atiyeh, 2007; Chen and Davidson, 2005; Berman, et al., 2005; Kono, et al., 2003; Alster, et al., 1995). Authors have also reported improvement in pliability and decreased symptoms with pulsed-dye laser therapy (Atiyeh, 2007; Alster, 2003; Dierickx, et al., 1995; Alster, 1994), in addition to improved healing of keloid scars when laser treatment is provided in combination with steroid therapy (Connell and Harland, 2000). The pulsed-dye laser works through absorption by oxyhemoglobin, causing a direct effect on the blood vessels and an indirect effect on the surrounding tissue. Pulsed-dye laser treatments for hypertrophic scars result in significant improvement after 1–2 laser treatments. Some authors report a greater treatment response when using multiple sessions employing lower energy densities. Keloids or thicker hypertrophic scars may require additional treatments.

Intralesional 5-fluorouracil is also an accepted method of treatment for hypertrophic and keloid scars. Intralesional 5-fluorouracil has been investigated, as off-label drug use, either as a monotherapy or adjuvant therapy, although there is a paucity of evidence evaluating 5-FU as an individual treatment modality. Evidence in the medical literature is limited and some authors have reported improved clinical outcomes while others have not. Authors contend 5-FU inhibits DNA synthesis and inhibits fibroblast proliferation inducing regression of keloids and hypertrophic scars. Kontochristopoulos et al. (2005) reported the results of a clinical trial involving 20 patients with keloid scars who were treated weekly with intralesional 5-FU. The authors acknowledged that administration of 5-FU did result in clinical improvement (i.e., reduction of keloid volume); however the

recurrence rate at one-year was 47%. Darougheh et al. (2008) conducted a double-blind clinical trial (n=40 patients) comparing intralesional triamcinolone combined with 5-FU to intralesional triamcinolone alone for the treatment of keloids. The combination of triamcinolone with 5-FU was more effective and provided a more rapid response (i.e., length, width, and height reduction; decrease in erythema; softening) with fewer side effects when compared to intralesional triamcinolone. Pruritus scores decreased in both treatment groups. Asilian et al. (2006) published results of a single-blinded clinical trial involving 69 patients who received intralesional triamcinolone (TAC), TAC plus 5-FU, or TAC, 5-FU and pulsed dye laser treatment for keloid scars. At 12 weeks follow-up all groups demonstrated acceptable improvement (i.e., erythema, pruritus, pliability, height, length and width). In comparison between groups, statistically significant differences were noted in the TAC plus 5-FU group and TAC plus 5-FU and pulsed dye laser group ($p < .05$ for both). The combination of TAC plus 5-FU and pulsed dye laser was reported as the best approach for treatment. In 2004 Nanda and Reddy noted, in a prospective randomized uncontrolled trial that the efficacy of 5-FU was comparable to other modalities as a treatment option for keloid scars. At 24 weeks follow-up, there was no recurrence of symptoms or lesions in 28 patients who received intralesional 5-FU. In 2002 Manuskiatti and Fitzpatrick conducted a prospective, paired comparison, randomized trial (n=10) evaluating intralesional corticosteroid therapy alone or combined with 5-FU, 5-FU alone, and pulsed dye laser for treatment of keloid and hypertrophic scars. Five scar segments were randomly treated with four different regimens. Outcome measures were assessed every eight weeks after treatment regimens (i.e., 32 week study period). Statistically significant clinical improvement was noted in all treated segments. Intralesional formulas resulted in more rapid resolution than pulsed dye laser. In the authors' opinion, 5-FU was comparable to other therapies. Additionally, Fitzpatrick (1999) reported successful outcomes (e.g., decreased pain, itching, softening of the scar, flattening) with intralesional 5-FU administered as a monotherapy, as well as combined with intralesional steroids, for treatment of hypertrophic scars and keloids. Intralesional 5-FU is associated with pain, although authors suggest the pain can be alleviated by the addition of triamcinolone acetonide or a field block anesthesia (Mutalik, 2005). This therapy has also been associated with ulceration at the injection site (Gupta and Kalra, 2002; Apikian and Goodman, 2004; Nanda and Reddy, 2004; Kontochristopoulos, 2005). While the evidence in the medical literature supporting 5 FU is limited, it is considered an accepted method of treating hypertrophic scars and keloids when combined with intralesional steroids.

Emerging Therapies

Evidence in the published scientific literature (Atiyeh, 2007; Berman, 2007; Levanthal, et al. 2006; Al-Attar, et al., 2006; Chen and Davidson, 2005; Berman, et al., 2004; Mustoe, et al., 2002) suggest that use of pharmacologic agents has shown potential benefit in the treatment of scar formation with varying degrees of success. Authors have reported there is some evidence of efficacy for scar treatment with intralesional injections of interferon, bleomycin, and verapamil hydrochloride, although studies are limited. Other emerging topical therapies are being investigated such as 5% imiquimod cream and retinoic acid, to name a few. Cytokines and/or agents that inhibit the effects of growth factors are also currently being investigated. These and other therapies have been used as either monotherapy or combined therapy. Some are considered off-label prescription drug use (e.g., interferon, bleomycin and verapamil). At this time, the evidence to support use of these emerging modalities is insufficient and does not allow strong conclusions regarding safety and efficacy. Clinical studies are few, generally involve small patient populations, lack controls, combine various types of therapies, and primarily evaluate short-term outcomes. Further large-scale prospective studies evaluating long-term outcomes, particularly for recurrence, are required before these treatments can be considered standard therapy.

Interferon: Systemic interferon has been shown to increase collagen breakdown producing an antifibrotic effect, and some authors have utilized interferon, intralesionally, to improve cosmetic appearance of scars. However, aside from the antiproliferative properties, interferon has been associated with considerable side effects (e.g., flu-like symptoms, fever, headache, and myalgia). Clinical efficacy of interferon, administered intralesionally, for treatment of scar tissue has not been consistently demonstrated in clinical trials. Davison et al. (2006) reported the results of a prospective trial evaluating intralesional interferon alpha-2b as post-excision therapy (n=13) and noted that the trial protocol was terminated at midtrial due to a high recurrence rate (54%); the control group (n=26) who received triamcinolone had a 15% recurrence rate. Smith et al. (2007) published a literature review regarding off-label uses of the interferons (gamma and alpha-2b) and reported that intralesional interferon gamma may be beneficial for the treatment of keloids and hypertrophic scars, however the number of patients studied is small, and interferon alpha-2b intralesionally appears less effective based on the evidence reviewed. In contrast, Lee et al. (2008) reported that intralesional interferon alpha-2b was safe and effective for the treatment of keloids. The authors compared outcomes of 20 lesions treated with a combination of triamcinolone

injection and interferon alpha-2b to twenty control lesions that received only triamcinolone injection. Both groups were treated with triamcinolone every two weeks for 24 weeks; the combined group also received intralesional interferon alpha-2b injection twice a week for 24 weeks. Lesion depth and volume changes were noted for both groups although statistically significant decreases were observed in the combined group. Further research is warranted to assess the clinical utility of interferon for the treatment of scars (Atiyeh, 2007; Al-Attar, et al., 2005; Mustoe, et al., 2002; Shaffer, et al., 2002).

Bleomycin: Bleomycin is reported to inhibit proliferation of scar tissue and is associated with various adverse effects due to toxicity. Although the evidence in the medical literature is limited to a few published trials, some investigators have used bleomycin with good response to treatment for keloid and hypertrophic scars, particularly when other treatments such as corticosteroids have failed to produce a successful clinical outcome. Administration of bleomycin by intradermal injection or the multipuncture method has been shown to be effective in reducing scar tissue and other symptoms, such as erythema, pruritus and pain (Saray and Gulec, 2005; Espana, et al., 2001). However, these two clinical trials involved small patient populations, short-term follow-up, and lacked comparison groups. Naecini et al. (2005) reported on 45 patients with hypertrophic scars or keloids that were randomly divided to receive either bleomycin tattoo or cryotherapy combined with intralesional triamcinolone injection. Both treatment groups had a high response rate (i.e., 88%), however for large lesions, the response rate was significantly better for bleomycin ($p=.03$). Aggarwal and colleagues (2008) reported that bleomycin may be used as a first-line treatment modality for management of keloid and hypertrophic scars. The group of authors evaluated 50 patients who received bleomycin applications for the treatment of keloids or hypertrophic scars. Eighty percent of patients showed satisfactory regression in size of the lesion while symptomatic relief of pruritus was obtained in 40 patients. Recurrence was seen in seven patients. Nonetheless, despite favorable response to bleomycin treatment regimens in these few trials, further investigation is needed to support the potential benefit of bleomycin therapy and improved long-term clinical outcomes.

Verapamil hydrochloride: Verapamil hydrochloride injection, a calcium-channel antagonist, has also been investigated as a treatment for scar tissue by some authors with promising results. Verapamil inhibits the synthesis /secretion of extracellular molecules, including collagen and increases collagenase, although the actual benefit of calcium antagonists on scars is not clearly established. Limited clinical trials have shown promising results. Cure rates of 54% have been reported in the published literature with a follow-up period extending to 18 months. Shaffer et al. (2002) reported that overall follow-up of one year is required to ensure a keloidal scar will not reappear. In a study by Copcu et al. (2004) it was reported that surgical excision with W-plasty or skin grafting and intralesional verapamil injection was a good alternative for the treatment of keloids. The study included 22 patients with keloids and one patient who developed a hypertrophic scar after blepharoplasty. After surgical excision all patients received intralesional verapamil injection. Patients were followed for two years after the operation and recurrences, characteristics of the lesions and symptoms were recorded. At two years post surgery, two patients had keloids smaller than the original lesions, two had lesions that looked like hypertrophic scars, four patients had pruritus and one patient developed a keloid at the donor site. In a randomized trial, Margaret Shanthi et al. (2008) compared the efficacy of verapamil with that of triamcinolone injections in treating hypertrophic scars and keloids. The authors noted that both drugs reduced vascularity, pliability, height and width of the scar after three weeks of treatment, with treatment effects present at one year post follow-up in a study population involving 54 patients. The rate of reduction was more rapid with triamcinolone injections, although verapamil resulted in less adverse drug reactions. In the author's opinion, verapamil may be considered an alternative to triamcinolone in the treatment of hypertrophic scars and keloids.

Professional Societies/Organizations

The American Society of Plastic Surgeons, the American Academy of Dermatology, and the American Osteopathic College of Dermatology provide information regarding various treatments aimed at improving the appearance of scars and scar revision. However, recommendations such as a formal guideline or a position statement could not be found regarding suggested treatments.

Summary

Revision of scar tissue solely to improve physical appearance is considered cosmetic and not medically necessary. When the presence of scar tissue results in a functional impairment or cause symptoms, revision may be medically necessary and can be performed by a variety of established techniques. Additional well-designed studies evaluating new and emerging therapies such as interferon, bleomycin and verapamil are necessary before the clinical utility of these treatments can be established.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

| CPT[®]* Codes | Description |
|-----------------------------------|--|
| 11400 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less |
| 11401 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm |
| 11402 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm |
| 11403 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm |
| 11404 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm |
| 11406 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less |
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm |
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm |
| 11440 | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less |
| 11441 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm |
| 11442 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm |
| 11443 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm |
| 11444 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm |
| 11446 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm |
| 15002 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children |
| 15003 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of |

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| | scar contracture, trunk, arms, legs; each additional 100 sq cm or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) |
| 15004 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children |
| 15005 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) |
| 15040 | Harvest of skin for tissue cultured skin autograft, 100 sq cm or less |
| 15100 | Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) |
| 15101 | Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15110 | Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children |
| 15111 | Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15115 | Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children |
| 15116 | Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15120 | Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) |
| 15121 | Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15130 | Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children |
| 15131 | Dermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15135 | Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children |
| 15136 | Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15200 | Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less |
| 15201 | Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm (List separately in addition to code for primary procedure) |
| 15220 | Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less |

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| 15221 | Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm (List separately in addition to code for primary procedure) |
| 15240 | Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less |
| 15241 | Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm (List separately in addition to code for primary procedure) |
| 15260 | Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less |
| 15261 | Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm (List separately in addition to code for primary procedure) |
| 15600 | Delay of flap or sectioning of flap (division and inset); at trunk |
| 15610 | Delay of flap or sectioning of flap (division and inset); at scalp, arms, or legs |
| 15620 | Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet |
| 15630 | Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips |
| 15650 | Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location |
| 15740 | Flap; island pedicle |
| 15750 | Flap; neurovascular pedicle |
| 15760 | Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area |
| 15770 | Graft; derma-fat-fascia |
| 31830 | Revision of tracheostomy scar |
| | Multiple/Varied |

| HCPCS Codes | Description |
|--------------------|--|
| J1700 | Injection, hydrocortisone acetate, up to 25 mg |
| J1710 | Injection, hydrocortisone sodium phosphate, up to 50 mg |
| J1720 | Injection, hydrocortisone sodium succinate, up to 100 mg |
| J9190 | Flourouracil, 500 mg |
| | Multiple/Varied |

| ICD-9-CM Diagnosis Codes | Description |
|---------------------------------|-------------------------------------|
| 701.4 | Keloid scar |
| 709.2 | Scar condition and fibrosis of skin |
| | Multiple/Varied |

Experimental/Investigational/Unproven/Not Covered when used to report services for the treatment of scar revision:

| CPT* Codes | 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 |
| 15780 | Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) |
| 15781 | Dermabrasion; segmental, face |
| 15782 | Dermabrasion; regional, other than face |

| | |
|-------|--|
| 15783 | Dermabrasion; superficial, any site, (eg, tattoo removal) |
| 15786 | Abrasion; single lesion (eg, keratosis, scar) |
| 15787 | Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure) |
| 15788 | Chemical peel, facial; epidermal |
| 15789 | Chemical peel, facial; dermal |
| 15792 | Chemical peel, nonfacial; epidermal |
| 15793 | Chemical peel, nonfacial; dermal |

| HCPCS Codes | Description |
|--------------------|--|
| J1825 | Injection, interferon beta-1a, 33 mcg |
| J1830 | Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) |
| J9040 | Bleomycin sulfate, 15 units |
| J9190 | Fluorouracil, 500 mg |
| J9212 | Injection, interferon alfacon-1, recombinant, 1 mcg |
| J9213 | Interferon alfa-2A, recombinant, 3 million units |
| J9214 | Interferon alfa-2B, recombinant, 1 million units |
| J9215 | Interferon alfa-N3, (human leukocyte derived), 250,000 IU |
| Q3026 | Injection, interferon beta-1a, 11 mcg for subcutaneous use |
| S0145 | Injection, pegylated interferon alfa-2a, 180 mcg per ml |
| S0146 | Injection, pegylated interferon alfa-2b, 10 mcg per 0.5 ml |
| | Multiple/Varied |

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