

Clinical Policy: Keloid Excision and Scar Revision

Reference Number: WNC.CP.190

Last Review Date:

Coding Implications

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description¹

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

Policy/Criteria¹

- I. WellCare of North Carolina® shall cover Keloid Excision or Scar Revisions when the member 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 member'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.
- II. WellCare of North Carolina® 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 Criteria I.

Background¹

- I. **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.

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- II. 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.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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

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CPT®* Codes	Description
11441	Excision, other 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, other 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, other 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, other 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, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
12031	Repair, intermediate, wounds of scalp, axillae, trunk, and/or extremities (excluding hands and feet); 2.5 cm or less
12032	Repair, intermediate, wounds of scalp, axillae, trunk, and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm
12034	Repair, intermediate, wounds of scalp, axillae, trunk, and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm
12035	Repair, intermediate, wounds of scalp, axillae, trunk, and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm
12036	Repair, intermediate, wounds of scalp, axillae, trunk, and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037	Repair, intermediate, wounds of scalp, axillae, trunk, and/or extremities (excluding hands and feet); over 30.0 cm
12041	Repair, intermediate, wounds of neck, hands, feet, and/or external genitalia; 2.5 cm or less
12042	Repair, intermediate, wounds of neck, hands, feet, and/or external genitalia; 2.6 cm to 7.5 cm
12044	Repair, intermediate, wounds of neck, hands, feet, and/or external genitalia; 7.6 cm to 12.5 cm
12045	Repair, intermediate, wounds of neck, hands, feet, and/or external genitalia; 12.6 cm to 20.0 cm
12046	Repair, intermediate, wounds of neck, hands, feet, and/or external genitalia; 20.1 cm to 30.0 cm
12047	Repair, intermediate, wounds of neck, hands, feet, and/or external genitalia; over 30.0 cm
12051	Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
12052	Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.6 cm to 5.0 cm

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CPT®* Codes	Description
12053	Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 5.1 cm to 7.5 cm
12054	Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 7.6 cm to 12.5 cm
12055	Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 12.6 cm to 20.0 cm
12056	Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 20.1 cm to 30.0 cm
12057	Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; over 30.0 cm
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
+13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
+13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 1.1 cm to 2.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 2.6 cm to 7.5 cm
+13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)
13151	Repair, complex, eyelids, nose, ears, and/or lips; 1.1 cm to 2.5 cm
13152	Repair, complex, eyelids, nose, ears, and/or lips; 2.6 cm to 7.5 cm
+13153	Repair, complex, eyelids, nose, ears, and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)
	The plus sign (+) denotes an add-on code.
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms, and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms, and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, and/or lips; defect 10 sq cm or less

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CPT®* Codes	Description
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
+14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
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)
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)
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, or part thereof (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
+15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, or part thereof (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, or part thereof (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, or part thereof (List separately in addition to code for primary procedure)

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	06/21
Reviewed CPT and ICD-10-CM codes.	03/22	05/22

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Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Annual Review. Added HCPCS codes: 13101 +13102 13120 13121 +13122 13131 13132 +13133 13151 13152 +13153. The plus sign (+) denotes an add-on code. Added ICD-10-CM codes 0HN0XZZ - 0HN9XZZ and 0HNAXZZ - 0HNNXZZ.	02/23	02/23
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual Review. Reviewed CPT and ICD-10-CM codes.	02/24	02/24
Annual Review. Reworded Criteria I A. and moved B into D. Updated text in Criteria II. To remove a list that was not inclusive. Removed “Note regarding ‘significant physical functional impairment.’” ICD-10-CM and HCPCS code tables removed. Removed “Medicaid and health choice’ verbiage from References.	11/24	11/24
Annual Review. Added CPT codes 14000-15261. Under NC Guidance/Claims related information, updated state web address.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1O-3 Keloid Excision and Scar Revision. [Program Specific Clinical Coverage Policies | NC Medicaid \(ncdhhs.gov\)](https://www.ncdhhs.gov/Program-Specific-Clinical-Coverage-Policies-NC-Medicaid). Published October 1, 2024. Accessed September 1, 2025.

North Carolina Guidance

Eligibility Requirements

- 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.

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.

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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.

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/>

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.

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

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- 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).

Claims-Related Information

Provider(s) shall comply with the NC Tracks 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 - as applicable to the service provided:
 - 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.
- 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.

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 - Providers shall follow applicable modifier guidelines.
- e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- f. Co-payments -
For Medicaid refer to Medicaid State Plan:
<https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices>
- g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

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members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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