Medical Coverage Policy

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Scar Revision

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, 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 customer'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 customer's benefit plan document always supersedes 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 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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy

will be denied as not covered. 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. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses methods employed for the revision of scar tissue.

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.

Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage.

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

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

Scar revision is considered medically necessary when ALL of the following criteria apply to the treated scar:

- is due to a history of external trauma (e.g., burn, blunt force trauma, penetrating trauma, laceration, surgical wound)
- is causing a functional impairment (e.g., restricted range of motion, lesion impacting a vital structure [such as nose, eyes])
- ANY of the following modalities is being utilized as monotherapy or combination therapy:
  - compression/pressure therapy
  - laser therapy*
  - surgery (grafting autologous soft tissue)
  - intralesional 5-fluorouracil

For keloid scar revision necessitating radiation therapy please use the following guideline: Radiation Oncology Clinical Guidelines

***NOTE: An initial regimen of laser therapy (CPT® Code 0479T, 0480T) includes up to six treatments. Continued laser therapy beyond the initial six treatments is considered medically necessary when there is a beneficial clinical response to the functional impairment as evidenced by successive objective measurements (e.g., range of motion, vision testing).**

Any other injectable medication, including the following, is considered not medically necessary for treatment of scar revision:

- bleomycin injections

- interferon therapy
- verapamil hydrochloride
- etanercept (Enbrel®)
- onabotulinum Toxin Type A (Botox® A)

Each of the following is considered cosmetic and not medically necessary:

- scar revision in the absence of a functional impairment
- 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):
    - collagen injections and fat transfers
    - liposuction
    - punch grafts

Each of the following is not covered or reimbursable:

- chemical peels
- dermabrasion

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Although people of any skin color can develop keloid or hypertrophic scarring, it is more prevalent in persons with more pigmented skin (Fitzpatrick IV, V and VI). Prevalence rates of keloid scarring are higher among Black, Asian, and Hispanic groups (4-16%) compared to Whites (0.09%). Researchers have found that the greater the presence of melanin in the body, the more likely one is to experience the development of keloids (Tchero, 2020; Glass, 2017).

General Background

Scars secondary to cutaneous injury often result in decreased tensile strength and permanent textural irregularity due to disturbed collagen production; this can be part of the natural healing process. Scars are often asymptomatic and do not result in a functional impairment. As a result, they do not require any intervention. Treatment of scars performed under these circumstances is considered cosmetic in nature and not medically necessary.

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 (McCrary et. al. 2021). They appear as nodules that can be painful, itchy and disfiguring. Keloids are most often found on the ears, upper back and chest, and upper arms. Keloid formation may result in pain, pruritus, hyperpigmentation and disfigurement (Porter, 2002). In some cases, keloids may become infected or ulcerate, and, in severe cases, the bulk of the tumor or the contraction of the scar may 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 and restricting 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

Keloids and hypertrophic scars may become symptomatic and require treatment. Associated symptoms include pain, pruritus, hyperhidrosis, functional impairment and cosmetic disfigurement. Although multiple medical and surgical therapies have been used for the treatment of keloids and hypertrophic scars, none of the treatments have been adequately evaluated in high-quality studies, and there is no universally established treatment approach. In most cases, combination therapies seem to provide fewer recurrences, particularly for the treatment of keloids. Standard methods that are employed for the revision of scar tissue include intralesional corticosteroid (e.g., triamcinolone acetonide), intralesional fluorouracil, silicone gel sheets, pressure therapy, radiation, laser therapy and surgical excision (Ogawa, 2022).

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. The current laser of choice for treating a hypertrophic and/or keloid scar, the vascular-specific pulsed-dye laser (Alster and Zaulyanov, 2007), has been recognized as a first-line treatment option (Meaume, et al., 2014; Atiyeh, 2007). 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. Research studies confirm that the 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., 2004; 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, 1995), in addition to improved healing of keloid scars when laser treatment is provided in combination with steroid therapy (Connell and Harland, 2000).

5-fluorouracil (5-FU) has been investigated as both monotherapy and adjuvant therapy for treatment of scar tissue, although evidence evaluating 5-FU as monotherapy is limited. Authors

contend 5-FU inhibits DNA synthesis and inhibits fibroblast proliferation inducing regression of keloids and hypertrophic scars. Evidence in the peer-reviewed published scientific literature supports the effectiveness of treatment for keloid and hypertrophic scars (Hietanen, et al., 2019; Khalid, et al., 2019; Kafka, et al., 2017; Srivastava, et al., 2017; Darougheh, et al., 2009; Asilian, et al., 2006; Kontochristopoulos, et al., 2005; Nanda and Reddy, 2004; Manuskiatti and Fitzpatrick, 2002; Fitzpatrick, 1999). Intralesional 5-FU may be associated with pain; however, 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 in some cases (Kontochristopoulos, 2005; Apikian and Goodman, 2004; Nanda and Reddy, 2004; Gupta and Kalra, 2002). A recent systematic review of 17 studies, involving 482 subjects who underwent either intralesional 5-FU alone, 5-FU combined with triamcinolone acetonide (TAC) or excision with 5-FU, with or without TAC, determined 5-FU was effective for treatment of keloids in 45–96% of the subjects, overall. When combined with TAC, the authors reported treatment was effective for 50–96% of subjects (Bijlard, et al., 2015). The authors acknowledged the level of evidence reviewed was poor, consisting of ten RCTs, four prospective single-arm trials, four case series, and one expert opinion, and noted meta-analysis was not able to be completed. In the authors' opinion, additional high-level clinical evidence is needed to support effectiveness, including dosing and injections schedules for administering 5-FU combined with TAC as treatment of keloids.

Emerging Therapies

Evidence in the published scientific literature (Berman, 2018; Jones, et al., 2015; Tziotzios, et al., 2012; Atiyeh, 2007; Leventhal, et al., 2006; Al-Attar, et al., 2006; Chen and Davidson, 2005; Berman, et al., 2004; Mustoe, et al., 2002) suggests that the use of some pharmacologic agents have potential benefit in the treatment of scar formation, with varying degrees of successful outcomes. Authors have reported there is some evidence of efficacy for scar treatment with intralesional injections of interferon, bleomycin, and verapamil hydrochloride. Other emerging topical therapies are being investigated such as mitomycin C, 5% imiquimod cream and retinoic acid. 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, although the optimal dosing, duration and frequency of treatment has yet to be established. 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 authors have utilized intralesional interferon 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 intralesional interferon for treatment of scar tissue has not been consistently demonstrated in clinical trials. Reported outcomes are generally mixed (Berman, et al., 2017; Lee, et al., 2008; Smith, et al., 2007; Davison, et al., 2006). Additional research is warranted to assess the clinical utility and overall benefit of using interferon for the treatment of scars (Shridharani, et al., 2010; Atiyeh, 2007; Al-Attar, et al., 2006; Mustoe, et al., 2002; Shaffer, et al., 2002).

Bleomycin: Bleomycin has been reported to inhibit proliferation of scar tissue. Evidence in the medical literature evaluating this use is limited to a few published trials evaluating use primarily as an alternative treatment when other modalities have failed. While some evidence supports

effectiveness for bleomycin by intradermal injection or the multipuncture method for reducing scar tissue and other symptoms, such as erythema, pruritus and pain (Saray and Güleç, 2005; España, et al., 2001), these clinical trials involved small patient populations, short-term follow-up, and lacked comparison groups. Naeini 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=0.03). 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 a 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.

Kim et al. (2020) conducted a systematic review and meta-analysis to compare the efficacy of bleomycin to corticosteroid and other treatments (i.e., triamcinolone acetonide [TAC], 5-FU, TAC combined with 5-FU, and TAC combined with cryotherapy) for keloids or hypertrophic scars. Five studies (n=375) including three randomized control trials and two controlled clinical trials met inclusion criteria. Inclusion criteria included: randomized controlled trial (RCT) and controlled clinical trial (CCT) regardless of allocation concealment and blinding; patients with keloid or hypertrophic scar; intervention types included bleomycin alone compared to other treatment methods; and outcome measures included changes of scar size related to height, patient self-assessment and observer assessments (POSAS), Vancouver scar scale (VSS), recurrence, and adverse effects. Outcome measures focused on scar size, recurrence and adverse events. Overall, the bleomycin group revealed more improvement in the scars than the non-bleomycin group, specifically compared to TAC, 5-FU, or combination of TAC with cryotherapy. Bleomycin was also found to reduce the recurrence rate compared to 5-FU alone or in combination with TAC. Hyperpigmentation, pain, pruritis, burn, vesicle/bullae, atrophy, ulceration, hypopigmentation, and telangiectasia were all adverse events reported in the studies with hyperpigmentation reported most frequently from those who received bleomycin. Author noted limitations included: insufficient articles and data lacking blinding and allocation concealment details; unreported volume use of bleomycin and size of keloid and hypertrophic scars; small patient populations; different methods of outcome assessment; and various follow-up periods. Additional randomized control trials with large patient populations are needed to support the reported outcomes of this study.

Verapamil hydrochloride: Verapamil hydrochloride injection, a calcium-channel antagonist, has also been investigated as a treatment for scar tissue by some authors. Verapamil inhibits the synthesis/secretion of extracellular molecules (including collagen) and increases collagenase, although the actual benefit of calcium antagonists on scar tissue is not clearly established. In comparison to triamcinolone injections, some authors have reported verapamil was as effective and resulted in less adverse drug reactions. Some studies have confirmed combination therapy has a more pronounced effect in the treatment of keloids and hypertrophic scars. Reported outcomes of some clinical trials have been promising (Klomparens, et al., 2022; Kant, et al., 2018; Margaret Shanthi, et al., 2008; Copcu, et al., 2004) although follow-up is short term and sample populations are small. One randomized controlled trial (Danielsen, et al., 2016), designed to compare verapamil to triamcinolone for the prevention of keloid recurrence (n=14), was terminated early. According to the authors, Kaplan-Meier survival curve analysis demonstrated a significantly higher recurrence rate with verapamil treatment at 12 months post-surgery and a higher overall risk of recurrence compared to triamcinolone injection. As a result, the remaining 16 subjects were not recruited as planned and the trial was terminated.

A randomized controlled trial conducted by Saki et al. (2019) compared the efficacy of intralesional triamcinolone acetonide with verapamil in the treatment of keloids. The study included adults aged 18–70 years old, with at least two scars with lesions less than two years old. Patients (n=15) with at least two scars were randomized to receive triamcinolone (TAC) as standard treatment and verapamil as the experimental drug. One of the scars received intralesional TAC while the other scar received intralesional verapamil hydrochloride. Treatment was every three weeks for a maximum of eight sessions or until complete flattening of the scar. Each intralesional session was preceded by cryotherapy. Scar evaluation at each stage was done by serial photographic records and using the Vancouver scar scale. In both groups, there was a reduction in height and pliability at the end of the study. However, there was a statistically significant improvement in height and pliability in the triamcinolone-receiving group compared to the verapamil-receiving group ($p<0.001$). A desired change in vascularity and pigmentation was not seen with either of the drugs ($p>0.05$). The authors concluded that verapamil is not as effective as triamcinolone in the treatment of keloids. Further studies with a higher number of participants and a longer period of observation are needed.

Abedini et al. (2018) conducted a randomized controlled trial that compared intralesional verapamil and intralesional corticosteroids in the treatment of keloids and hypertrophic scars. Patients (n=50) were randomized to the control group (n=50 lesions) or to the treatment group (n=50 lesions). The control group received intralesional triamcinolone acetonide (40mg/mL) injections at three-week intervals for 18 weeks. The treatment group received verapamil (2.5mg/mL) with the same therapeutic sessions. Treatments were continued for a maximum of six sessions or until complete flattening of the scar, whichever came first. Then, patients were followed for three months regarding recurrence of lesions and side effects. The study included adults aged 18–65 years with two or more keloids and hypertrophic scars, without previous treatment of any type and lesions less than five years old. The outcomes measured the efficacy, safety profile and recurrence rates of hypertrophic scars and keloids when treated with verapamil or corticosteroid. The scar was assessed by clinical examination at each injection and at the end of three months using Vancouver Scar Scale (height, pigmentation, pliability, and vascularity), digital photograph, and patient reported pain during treatment. The clinical improvement was defined as decreasing values of the scores. Complete recovery was considered if scores reached zero. Three patients were lost to follow-up. Verapamil-treated lesions showed reducing scores of pliability at week 12 and height at week 15. However, vascularity and pigmentation scores did not reveal any change during 18 weeks of treatment. Therefore, verapamil was considered not effective in reducing the scores of Vancouver scar assessment scale (VSS) parameters (height, pigmentation, pliability, and vascularity) to the treatment goal of zero. In triamcinolone-treated lesions, the efficacy of therapy was observed on all VSS parameters from week three, and the mean test time to complete recovery for the height and pliability parameters was 15 weeks. In triamcinolone treated lesions, vascularity and pigmentation did not reach the treatment goal of zero. Treatment side effects included pain and burning during injection (84%) mostly in verapamil treated lesions. Moreover, 73.3% of verapamil group against 88.2% of triamcinolone group were satisfied with the resolution of symptoms like burning, pruritus and pain at the end of therapy. In triamcinolone-treated lesions, the recurrences of pigmentation, pliability, height, and vascularity occurred in 0, 6%, 10%, and 2% of treated patients, respectively. In verapamil-treated lesions, no recurrences of the parameters mentioned above were observed. Author noted limitations included short term follow-up and lack of placebo group. The authors concluded that verapamil is not a suitable and effective alternative to triamcinolone in the treatment of keloids and hypertrophic scars.

Evidence in the published medical literature remains insufficient to firmly establish safety and efficacy of verapamil compared to conventional scar treatments.

Etanercept: Etanercept (Enbrel®) is a tumor necrosis factor alpha antagonist being investigated for the treatment of excessive scarring. Injecting etanercept intralesionally theoretically reduces local inflammatory and fibrotic activity within keloid scars. Evidence evaluating safety and efficacy is lacking. However, one group of authors (Berman, et al, 2008) compared etanercept with triamcinolone acetonide (TAC) for the treatment of keloids (n=20). Subjects were randomly assigned to receive either etanercept or TAC for two months. Both treatments were safe, well tolerated and improved parameters such as reduction in keloid height, erythema and pruritus. TAC was more effective in improving keloid height and volume. Etanercept was more effective in reducing erythema and pruritus. Although these reported outcomes are promising, further studies are needed to support safety, efficacy and overall clinical utility compared to other well-established treatments.

Botulinum Toxin Type A: Botulinum toxin type A (BTXA, Botox® A) intralesional injection has been investigated as a treatment for keloid scars (Zhang, et al., 2016; Prodromidou, et al., 2015; Gupta and Sharma, 2011; Xiao, et al., 2010; Uyesugi, et al., 2010; Zhibo and Miaobo, 2009). BTXA is considered a potent growth factor involved in wound healing and theoretically has anti-hypertrophic scar properties, although the molecular mechanism is not clearly established.

Rasaii et al. (2019) conducted a double-blind, randomized controlled pilot study to compare the efficacy of intralesional triamcinolone used alone or in combination with Botulinum Toxin A (BTA) in the treatment of formed keloid scars. Patients with at least two keloid scars who had not received any medical or physical treatments for keloids in the past three months were considered for study enrollment. Two keloids in each patient (n=23) were randomly assigned to receive intralesional triamcinolone acetonide plus placebo (Group A) or intralesional triamcinolone acetonide plus BTA (Group B). Each patient was blinded to the therapy received by each keloid. Each keloid underwent the assigned therapeutic intervention every four weeks for a total of three sessions. Outcomes measured the height, vascularity, pigmentation and pliability of keloid scars at baseline using the Vancouver scar assessment scale (VSS), during sessions 1–3 and during a one month follow-up visit. Secondary outcomes measured the severity of pain and itching using a visual analogue scale. There was no significant difference in therapeutic efficacy between the two groups at one month follow-up. A significant decrease in the pain and pruritus score was noted in both groups, with Group B showing a significant decrease in pain and pruritus scores compared to Group A ($p<0.001$). The authors concluded that triamcinolone acetonide used alone, or combined with BTA, provides similar clinical results in terms of scar improvement and symptom control. Future studies with intralesional triamcinolone and BTA are needed.

Overall, evidence in the published scientific literature is insufficient to support safety and efficacy at this time and further research is necessary to establish the benefit of this therapy in treating keloid scars.

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.

Medicare Coverage Determinations

	Contractor	Determination Name/Number	Revision Effective Date
NCD	National	Laser Procedures (140.5)	05/01/1997

	Contractor	Determination Name/Number	Revision Effective Date
LCD		No Local Coverage Determination found	

Note: Please review the current Medicare Policy for the most up-to-date information.
(NCD = National Coverage Determination; LCD = Local Coverage Determination)

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm^2 or part thereof, or 1% of body surface area of infants and children
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm^2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)

HCPCS Codes	Description
J9190	Injection, fluorouracil, 500 mg

Considered Not Medically Necessary/Cosmetic 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
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate

CPT®* Codes	Description
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure).
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue

Not Covered or Reimbursable:

CPT®* Codes	Description
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)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal

Considered not medically necessary when used to report other injectable intralesional treatment of scar revision:

HCPCS Codes	Description
J0585	Injection, onabotulinumtoxinA, 1 unit
J0586	Injection, abobotulinumtoxinA, 5 units
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1826	Injection, interferon beta-1a, 30 mcg
J1830	Injection, interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J9040	Injection, bleomycin sulfate, 15 units
J9212	Injection, interferon alfacon-1, recombinant, 1 microgram
J9213	Injection, interferon alfa-2A, recombinant, 3 million units
J9214	Injection, interferon alfa-2B, recombinant, 1 million units
J9215	Injection, interferon alfa-N3, (human leukocyte derived), 250,000 IU
J9216	Injection, interferon, gamma 1-B, 3 million units
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use
S0145	Injection, pegylated interferon alfa-2a, 180 mcg per ml

HCPCS Codes	Description
S0148	Injection, pegylated interferon ALFA-2B, 10 mcg

***Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.**

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Revision Details

Type of Revision	Summary of Changes	Date
Annual Review	Removed policy statements for: intralesional corticosteroid injections, silicone gel sheeting and silicone combination kits, excision, skin grafting, and flap surgery.	04/15/2025
Focused Review	Removed radiation treatment modality and added hyperlink to EviCore guideline	03/15/2025
Annual Review	No changes to coverage.	04/15/2024