

Corporate Medical Policy

Collagen Implantation

File Name:	collagen_implantation
Origination:	6/1994
Last CAP Review:	6/2006
Next CAP Review:	n/a
Last Review:	6/2006

Active policy, no longer scheduled for routine literature review.

Description of Procedure or Service

Collagen implantation uses purified collagen derived from bovine hide. It may be lightly cross-linked with glutaraldehyde or noncross-linked.

Noncross-linked collagen is used to restore the natural skin contour to nonweight bearing areas which have been damaged by age, trauma, disease, congenital anomalies, or previous therapeutic procedures. Typically, supplemental implants are required for most patients between 6- 18 months post-procedure (Collagen Corporation, 1986) due to the degeneration of the original implant.

Cross-linked collagen is proposed for use for all of the same indications in which noncross-linked collagen is used for the subdermal augmentation of soft tissues. An additional indication is subdermal augmentation beneath keratotic lesions of the foot. Enhanced durability, with less frequent need for supplementation, is the major advantage cited for cross-linked collagen implants. Another indication is periurethral (through the urethra or tube through which urine passes from the bladder to outside of the body) injection of cross-linked collagen for treatment of stress urinary incontinence (inability to control urination).

Collagen is the major protein component of the white fibers that form connective tissue, cartilage and bone in mammals.

*****Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

Policy

BCBSNC will provide coverage for Collagen Implantation when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

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When Collagen Implantation is covered

Collagen Implantation is covered for the following indications:

- Noncross-linked collagen is eligible for coverage to augment soft tissue when it is performed for reconstructive purposes as defined in the Cosmetic and Reconstructive Surgery Policy.
- It is eligible for coverage for the treatment of corns and callouses (Keragen implant).

For the treatment of urinary incontinence see policy titled Urinary Incontinence, Treatment.

When Collagen Implantation is not covered

For any condition other than those shown above

Policy Guidelines

Not Applicable

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 11950, 11951, 11952, 11954, G0429, Q2026, Q2027, C9800

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

BCBSA Medical Policy Reference Manual

Podiatry Advisory Group - 4/86

Medical Policy Advisory Group review 5/99

Specialty Matched Consultant Advisory Panel - 10/2000

Medical Policy Advisory Group 10/2000

Specialty Matched Consultant Advisory Panel - 5/2001

Specialty Matched Consultant Advisory Panel - 9/2002

Specialty Matched Consultant Advisory Panel - 7/2004

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Policy Implementation/Update Information

- 8/83 Original policy: Considered generally accepted medical practice for noncross-linked collagen when procedure is reconstructive
- 7/86 Evaluated: Investigational for cross-linked collagen for subdermal augmentation of soft tissues of the foot
- 8/88 Reviewed: Eligible for coverage for noncross-linked collagen implantation and investigational for cross-linked collagen implantation
- 1/97 Revised: Combined local and national policies. Added "collagen covered for treatment of corns and callouses"
- 5/99 Reaffirmed based on the MPAG review. No changes.
- 7/99 Reformatted, Description of Procedure or Service changed, Medical Term Definitions added.
- 10/00 Specialty Matched Consultant Advisory Panel review. Removed words "Non-Cross Linked" from policy section of medical policy. System coding changes. Medical Policy Advisory Group review. No further changes to criteria. Approve.
- 5/01 Revised. Under section, When Collagen Implantation is covered, bullet 2, removed the criteria for stress urinary incontinence and referenced the policy for Urinary Incontinence, Treatment. Specialty Matched Consultant Advisory Panel. No changes to policy. Coding format changes.
- 10/02 Specialty Matched Consultant Advisory Panel review. No change to criteria. Reaffirm policy.
- 3/04 Benefits Application and Billing/Coding sections updated for consistency.
- 8/12/04 Specialty Matched Consultant Advisory Panel review 7/14/2004. Removed criteria related to the urinary incontinence under section When Collagen Implantation is Covered and referenced the policy titled Urinary Incontinence, Treatment. Removed CPT code 51715 in that it does not apply to this policy. References added.
- 7/24/06 Specialty Matched Consultant Advisory Panel review 6/20/2006. No changes to policy statement. References added. Active Archive, policy no longer scheduled for routine literature review.
- 10/22/07 File name added to "Key Words" section. (btw)
- 6/22/10 Policy Number(s) removed (amw)
- 10/26/10 Added new codes to policy: G0429, Q2026, Q2027, C9800(mco)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its

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medical policies periodically.