Policy and Procedure

Title: Chemical Peels and Dermabrasion	Division: Medical Management Department: Utilization Management
Approval Date: 9/24/21	LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP, UltraCare
Effective Date: 10/25/19	Policy Number: UM-MP249
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Retired Date:	Page 1 of 5

1. POLICY DESCRIPTION:

Chemical peels and dermabrasion are skin resurfacing procedures that remove the epidermis and superficial layers of skin to allow re-epithelization. They are generally utilized for treating large areas where lesions are multiple and diffuse. Both procedures are established dermatological treatments for specific skin conditions and may be recommended for the treatment of precancerous lesions however, in many cases these methods of treatment do not improve function and are utilized strictly for improving personal appearance and are considered cosmetic.

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:

Actinic keratosis: Common skin lesions associated with extended exposure to the sun that are generally considered to be a precursor of squamous cell carcinoma (SCC).
Superficial chemical peel: Alpha-hydroxy acid or other mild acid is used to penetrate only the outer layer of skin to gently exfoliate it.
Medium chemical peel: Glycolic or trichloro acetic acid is applied to penetrate the outer and middle layers of skin.
Deep chemical peel: Trichloro acetic acid or phenol is applied to deeply penetrate the middle layer of skin.
Dermabrasion: Removal of the epidermis and superficial dermis to allow for re-epithelialization from the underlying skin to occur. A specialized hand-held instrument is used to “sand” the skin to remove the epidermal surface and improve contour.

4. POLICY:

Chemical Peels

1. MetroPlus considers medium and deep chemical peels medically necessary for the following indications:
    a. Treatment of numerous (10 or more) actinic keratosis or other pre-malignant skin lesions when it would be impractical to treat each lesion individually AND:
    b. Unless contraindicated, the member has failed to respond to a trial of one or more conservative treatments:
        i. Topical chemotherapy agents with 5-flourouracil (5-FU) or imiquimod
        ii. Photodynamic therapy with Aminolaevulinic Acid HCL (5-ALA)
        iii. Curettage and excision

iv. Cryotherapy

c. Treatment of active moderate-to-severe acne in members who have failed to respond to a 6-week trial (unless otherwise specified) of each of the following treatment options
   i. At least 2 topical agent regimens: benzoyl peroxide, dapsone, Salicylic /Azelaic acid; topical retinoid (adapalene, tretinoin); topical antibiotic (erythromycin, clindamycin); combination of topical agents;
   ii. At least 2 oral antibiotics (doxycycline, minocycline, erythromycin, azithromycin)
   iii. A full treatment course of oral isotretintion (5 months of therapy)

Dermabrasion

1. MetroPlus considers dermabrasion medically necessary for the treatment of actinic keratosis or other pre-cancerous actinic keratosis lesions when:
   a. lesions are diffuse (e.g., ≥ 10 lesions) making targeted therapy impractical
   b. Conventional methods of removal such as cryotherapy, curettage and excision are impractical due to high number and distribution of lesions AND
   c. Unless contraindicated, the member has failed to respond to a trial of one or more of the following topical treatments:
      i. 5-fluorouracil (5-FU)or imiquimod;
      ii. Photodynamic therapy with Aminolaevulinic Acid HCL (5-ALA)

2. MetroPlus considers dermabrasion not medically necessary for the treatment of active acne as this treatment can pose a greater risk of infection and may exacerbate skin inflammation.

Chemical Exfoliation

1. Chemical Exfoliation (CPT 17360) for treatment of acne vulgaris or ANY other indication is considered cosmetic and not medically necessary.

5. LIMITATIONS/ EXCLUSIONS:

MetroPlus considers chemical peels and dermabrasion cosmetic in nature, and therefore not a covered benefit, for the following indications including but not limited to:

- Acne scarring
- Microdermabrasion or superficial dermabrasion (CPT 15783) for any indication
- Epidermal chemical peels (CPT 15788, 15792) for any indication
- Contouring/discoloration/hyperpigmentation (e.g., dermatosis papulosa nigra, rosacea)
- Dull complexity

- Ephelides (freckles)
- Fine/fewer lines and wrinkles
- Lentigines (liver spots; aka age spots)
- Melasma
- Photoaged skin
- Removal of tattoos
- Rhinophyma
- Sebaceous hyperplasia (aka senile hyperplasia)
- Seborrheic keratoses
- Skin roughness

6. APPLICABLE PROCEDURE CODES:

CPT	Description
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15789	Chemical peel, facial; dermal
15793	Chemical peel, non-facial; dermal

7. APPLICABLE DIAGNOSIS CODES:

CODE	Description
D48.5	Neoplasm of Uncertain Behavior of Ski
L57.0	Actinic keratosis

8. REFERENCES:

- American Society for Dermatologic Surgery. Chemical Peels. https://www.asds.net/skin-experts/skin-treatments/chemical-peels
  Kraft J, Freiman A. Management of acne. *CMAJ*. 2011;183(7):E430-E435. Doi:10.1503/cmaj.0903
- CMS Decision Memo for Actinic Keratoses (CAG-00049N) July 19, 2001 https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=129&ncdver=1&DocID=250.4&bc=gAAAAgAAAAAAA%3d%3d&
- Cleveland Clinic. Common Benign Growths. June 2017. http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/dermatology/common-benign-growths/ Accessed October 14, 2022.
- National Comprehensive Cancer Network. NCCN Guidelines Squamous Cell Skin Cancer. Version 2.2022 — May 2, 2022 http://www.nccn.org/professionals/physician_gls/pdf/squamous.pdf. Accessed September 10, 2019.

REVISION LOG:

REVISIONS	**DATE**
Creation date	9/10/19
Annual Review	10/2/2020
Annual Review	9/24/2021
Annual Review	10/31/2022

Approved:	**Date:**	**Approved:**	**Date:**
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Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus

Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.
MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.