# Medical Policy:

## Dermabrasion

| POLICY NUMBER | LAST REVIEW |
|---|---|
| MG.MM.ME.55C6 | December 10, 2021 |

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The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as "EmblemHealth"), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth 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). EmblemHealth 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 and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. 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 web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

## Definitions

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| Actinic keratosis (AK) | Actinic keratoses (AKs or solar keratoses) are keratotic macules, papules, or plaques resulting from the intraepidermal proliferation of atypical keratinocytes in response to prolonged exposure to ultraviolet radiation. Although most AKs do not progress to squamous cell carcinoma (SCC), AKs are a concern because the majority of cutaneous SCCs arise from pre-existing AKs, and AKs that will progress to SCC cannot be distinguished from AKs that will spontaneously resolve or persist.<br>Accepted primary treatment modalities include cryotherapy, topical 5-fluorouracil, topical imiquimod, photodynamic therapy (eg, amino levulinic acid [ALA], porfimer sodium), and curettage and electrodesiccation. |
| Dermabrasion | Ablative procedure, which removes the epidermis and superficial dermis of the skin. Resurfacing is achieved by planing or sanding; usually by means of a rapidly rotating abrasive tool (wire brush, diamond fraise, or serrated wheel). Laser dermabrasion involves use of an argon laser, ultrapulse carbon dioxide (CO2) laser or flashlamp-pumped pulsed dye laser to resurface the entire face and has been used as an alternative to standard dermabrasion in treating patients with inactive acne with disfiguring scarring. (See Limitations/Exclusions) |

## Related Guidelines

Cosmetic and Reconstructive Surgery Procedures
Phototherapy, Photochemotherapy and Photodynamic Therapy for Dermatologic Conditions

## Guideline

Dermabrasion using controlled surgical scraping (dermaplaning) or carbon dioxide ($CO_2$) laser is considered medically necessary for the removal of superficial basal cell carcinomas and pre-cancerous AK lesions; both:

1. Conventional methods of removal (e.g., cryotherapy, curettage and excision) are impractical due to the number and distribution of the lesions
2. Failed trial of 5-fluorouracil (5-FU) (Efudex) or imiquimod (Aldara); unless contraindicated

## Limitations/Exclusions

1. Dermabrasion is not considered medically necessary for the treatment of active acne vulgaris due to insufficient evidence of therapeutic value.
2. Dermabrasion is not considered medically necessary when for the following cosmetic purposes (list not all-inclusive):
    a. Acne scarring (case-by-case review when documentation substantiating medical necessity is submitted to the plan)
    b. Contouring/discoloration/hyperpigmentation (e.g., dermatosis papulosa nigra, rosacea)
    c. Dull complexity
    d. Ephelides (freckles)
    e. Fine/fewer lines and wrinkles
    f. Lentigines (liver spots; aka age spots)
    g. Melasma
    h. Photoaged skin
    i. Sebaceous hyperplasia (aka senile hyperplasia)
    j. Seborrheic keratoses
    k. Skin roughness
    l. Tattoo removal

## Procedure Codes

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| 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) |

## ICD-10 Diagnoses

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| C44.01 | Basal cell carcinoma of skin of lip |
| C44.111 | Basal cell carcinoma of skin of unspecified eyelid, including canthus |

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| C44.112 | Basal cell carcinoma of skin of right eyelid, including canthus |
| C44.1121 | Basal cell carcinoma of skin of right upper eyelid, including canthus |
| C44.1122 | Basal cell carcinoma of skin of right lower eyelid, including canthus |
| C44.119 | Basal cell carcinoma of skin of left eyelid, including canthus |
| C44.1191 | Basal cell carcinoma of skin of left upper eyelid, including canthus |
| C44.1192 | Basal cell carcinoma of skin of left lower eyelid, including canthus |
| C44.211 | Basal cell carcinoma of skin of unspecified ear and external auricular canal |
| C44.212 | Basal cell carcinoma of skin of right ear and external auricular canal |
| C44.219 | Basal cell carcinoma of skin of left ear and external auricular canal |
| C44.310 | Basal cell carcinoma of skin of unspecified parts of face |
| C44.311 | Basal cell carcinoma of skin of nose |
| C44.319 | Basal cell carcinoma of skin of other parts of face |
| C44.41 | Basal cell carcinoma of skin of scalp and neck |
| C44.510 | Basal cell carcinoma of anal skin |
| C44.511 | Basal cell carcinoma of skin of breast |
| C44.519 | Basal cell carcinoma of skin of other part of trunk |
| C44.611 | Basal cell carcinoma of skin of unspecified upper limb, including shoulder |
| C44.612 | Basal cell carcinoma of skin of right upper limb, including shoulder |
| C44.619 | Basal cell carcinoma of skin of left upper limb, including shoulder |
| C44.711 | Basal cell carcinoma of skin of unspecified lower limb, including hip |
| C44.712 | Basal cell carcinoma of skin of right lower limb, including hip |
| C44.719 | Basal cell carcinoma of skin of left lower limb, including hip |
| C44.81 | Basal cell carcinoma of overlapping sites of skin |
| C44.91 | Basal cell carcinoma of skin, unspecified |
| D48.5 | Neoplasm of uncertain behavior of skin |
| L57.0 | Actinic keratosis |

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## Revision History

| Company(ies) | DATE | REVISION |
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| ConnectiCare | Aug. 5, 2019 | ConnectiCare adopts the clinical criteria of its parent corporation Emblem Health |

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