Medical Policy:
Dermabrasion (Commercial)

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<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
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<tr>
<td>MG.MM.ME.55C4</td>
<td>08/09/2019</td>
<td>MPC (Medical Policy Committee)</td>
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**IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:**

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. 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. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare 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). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. 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. Each benefit plan 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 ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

**Definitions**

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<th>Actinic keratosis (AK)</th>
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<td>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. Accepted primary treatment modalities include cryotherapy, topical 5-fluorouracil, topical imiquimod, photodynamic therapy (e.g., amino levulinic acid [ALA], porfimer sodium), and curettage and electrodessication.</td>
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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 Surgery Procedures
Phototherapy, Photochemotherapy and Photodynamic Therapy for Dermatologic Conditions

Guideline
Dermabrasion using controlled surgical scraping (dermaplaning) or carbon dioxide (CO2) 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

Limitation/Exclusion
1. Dermabrasion is not considered medically necessary for the treatment of acne vulgaris due to insufficient evidence of therapeutic value.
2. Dermabrasion is not considered medically necessary for any of the following (list not all-inclusive):
   a. Acne scarring (case-by-case review when documentation substantiating medical necessity is submitted to the plan)
   b. Contouring/discholoration/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
Dermabrasion

Medical

References


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(WMHTAC); 1998.
Specialty matched clinical peer review.

Revision history

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<td>08/05/2019</td>
<td>1.Reformatted and reorganized policy, transferred content to new template 2. Connecticare has adopted the clinical criteria of its parent corporation, EmblemHealth.</td>
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