

Medical Policy:

Dermabrasion

POLICY NUMBER	LAST REVIEW
MG.MM.ME.55C8	November 11, 2024

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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

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. 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 (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

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 complexion
 - 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

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

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

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
ConnectiCare	Aug. 5, 2019	ConnectiCare adopts the clinical criteria of its parent corporation Emblem Health