

## Dermabrasion & Chemical Peels

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Dermabrasion and chemical peels are skin resurfacing procedures that remove the epidermis and superficial layers of skin to allow re-epithelialization. These types of treatment are generally employed for treating large areas where lesions are multiple and diffuse. Standard dermabrasion uses a wire brush or a stainless steel wheel on which diamond chips have been bonded (diamond fraise) abrasers to plane the skin whereas laser dermabrasion involves use of the argon laser, ultrapulse carbon dioxide (CO<sub>2</sub>) laser, or flashlamp-pumped pulsed dye laser.

The following CPT codes require preauthorization:

- ❖ 15780 - Dermabrasion, Total Face
- ❖ 15781 - Dermabrasion, Segmental, Face
- ❖ 15782 - Dermabrasion, Regional, Other than Face
- ❖ 15786 - Abrasion, Single Lesion
- ❖ 15787 - Abrasion, Each Additional 4 Lesions
- ❖ 15788 - Chemical Peel, Facial; Epidermal
- ❖ 15789 - Chemical Peel; Dermal
- ❖ 15792 - Chemical Peel, Nonfacial: Epidermal
- ❖ 15793 - Chemical Peel, Nonfacial; Dermal

### I. Criteria for Initial Approval

Dermabrasion and chemical peels will be considered for coverage when **all** of the criteria below are met, confirmed with supporting medical documentation.

- Adults 18 years of age and older.
- Performed by a dermatologist or plastic surgeon.
- Patient has a diagnosis of either: actinic keratoses, basal cell carcinoma, and/or rhinophyma.

**Chemical Peels (CPT 15789, 15793)** are considered medically necessary for the treatment of:

- Actinic keratoses when BOTH of the following criteria are met:
  - Lesions are diffuse (e.g.,  $\geq 10$  lesions) making targeted therapy impractical; AND

- Failure, contraindication or intolerance to one or more conventional therapy treatments (e.g., topical 5-fluorouracil [5-FU, Efudex], topical diclofenac, photodynamic therapy [PDT], topical imiquimod [Aldara]).

**Dermabrasion (CPT 15780, 15781, 15782)** is considered medically necessary for the treatment of:

- Rhinophyma when significant enough to lead to functional problems such as nasal airway obstruction, including sleep apnea.
- Superficial basal cell carcinomas and precancerous actinic keratoses lesions when BOTH of the following criteria are met:
  - Conventional methods of removal (e.g., cryotherapy, curettage and excision) are impractical due to the number and distribution of the lesions; AND
  - Failed trial of 5-fluorouracil (5-FU) (Efudex) or imiquimod (Aldara); unless contraindicated.

**Epidermal Chemical Peels and Abrasion Therapy (CPT 15786, 15787, 15788, 15792)** are typically considered cosmetic and will be evaluated on a case-by-case basis to determine if therapy provides restoration of physiologic function or an improvement in functional impairment.

## II. Required Clinical Information

### **Dermabrasion and Chemical Peel:**

Criteria for coverage (in **Section I.**) must be met. The following clinical information must be provided:

- Recent history and physical exam.
- Imaging of lesions to be treated.
- Pathology report to confirm diagnosis.
- Diagnosis and description of functional impairment that supports the need for dermabrasion and/or chemical peel as medically necessary.

## III. Coverage Limitations and Exclusions

The following procedures will be considered cosmetic or not medically reasonable or necessary when performed for the reasons listed below:

- Chemical Peel - when performed for any other indication not listed above, such as:
  - Chemical exfoliation for acne;
  - Cosmetic indications when done for aging skin (e.g., skin damage due to overexposure to sun, etc.), wrinkles, acne scarring; or

- Using chemical peel and hydrating agents that do not require physician supervision for application.
- Dermabrasion - when performed for (list may not be all inclusive):
  - Acne or acne scarring (case-by-case review when documentation substantiating medical necessity is submitted to the plan);
  - Contouring/discoloration/hyperpigmentation (e.g., dermatosis papulosa nigra, rosacea);
  - Dull complexion;
  - Ephelides (freckles);
  - Fine/fewer lines and wrinkles;
  - Lentiginos (liver spots; aka age spots);
  - Melasma;
  - Photoaged skin;
  - Sebaceous hyperplasia (aka senile hyperplasia);
  - Seborrheic keratoses;
  - Skin roughness; or
  - Tattoo removal.
- Microdermabrasion for the treatment of any indication is considered cosmetic.
- Superficial dermabrasion (**CPT 15783**) for any indication is considered cosmetic.

#### IV. Length of Authorization for Initial Therapy

Dermabrasion and/or chemical peel procedures will be preauthorized for 3 months when criteria for initial approval are met.

#### V. Billing Code/Information

CPT/HCPCS Codes:

- ❖ 15780 - Dermabrasion, Total Face.
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*Prior authorization of benefits is not the practice of medicine nor the substitute for the independent medical judgment of a treating medical provider. The materials provided are a component used to assist in making coverage decisions and administering benefits. Prior authorization does not constitute a contract or guarantee regarding member eligibility or*

*payment. Prior authorization criteria are established based on a collaborative effort using input from the current medical literature and based on evidence available at the time.*

**Approved by MDH Clinical Criteria Committee: 09/28/2021**  
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