
Medical Policy



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***Current Policy Effective Date: 9/1/24**
(See policy history boxes for previous effective dates)

Title: Chemical Peels

Description/Background

CHEMICAL PEELS

Chemical peels involve a controlled partial-thickness removal of the epidermis and the outer dermis. When skin is regenerated, a 2- to 3-mm band of dense, compact collagen is formed between the epidermis and the damaged layers of the dermis, resulting in ablation of fine wrinkles and a reduction in pigmentation. These changes can be long-term, lasting 15 to 20 years and may be permanent in some individuals. Potential local complications include scarring, infection, hypopigmentation, hyperpigmentation, activation of herpes simplex, and toxic shock syndrome.¹

Types of Peels

Chemical peels are often categorized by the depth of the peel: categories include superficial, medium-depth, and deep chemical peels. The precise depth of the peel depends on the concentration of the agent used, duration of the application, and the number of applications. Possible indications for each type of peel and common chemicals used, as described by Cummings et al (2005)² and others, is as follows.

Superficial Peels

Superficial peels (epidermal peels) affect the epidermis and the interface of the dermis-epidermis. This depth is considered appropriate for treating mild photoaging, melasma, comedonal acne, and postinflammatory erythema. Common chemical agents used for superficial peels include low concentrations of glycolic acid, 10% to 20% trichloroacetic acid (TCA), Jessner solution (a mixture of resorcinol, salicylic acid, lactic acid, and ethanol), tretinoin, and salicylic acid. As part of the treatment process, superficial peels generally cause mild erythema and desquamation, and healing time ranges from 1 to 4 days, depending on the strength of the chemical agent. With superficial peels, Individuals often undergo multiple sessions, generally 6 to 8 peels performed weekly or biweekly.

Medium-Depth Peels

Medium-depth peels (dermal peels) extend into the epidermis to the papillary dermis. They are used for moderate photoaging, actinic keratoses, pigmentary dyschromias, and mild acne scarring. In the past, 50% TCA was a common chemical agent for medium-depth peels, but its use has decreased due to high rates of complications (eg, pigmentary changes, scarring). Currently, the most frequently used agent is a combination of 35% TCA with Jessner solution or 70% glycolic acid. Phenol 88% alone is also used for medium-depth peels. The healing process involves mild-to-moderate edema, followed by the appearance of a new, erythematous epithelium. Individuals are advised to wait at least 3 months before resuming skin care services (eg, superficial chemical peels) and repeat medium-depth chemical peels should not be performed for at least 1 year.

Deep Peels

Deep chemical peels (another type of dermal peel) penetrate the mid-reticular dermis and have been used for Individuals with severe photodamage, premalignant skin neoplasms, acne scars, and dyschromias. The most common chemical agent used is Baker solution (which consists of 3 mL of 88% phenol, 8 drops of hexachlorophene [Septisol], 3 drops of croton oil, 2 mL of distilled water). The same depth can be achieved using 50% or greater TCA peel; however, the latter has a higher risk of scarring and pigmentation problems. Phenol is cardiotoxic, and individuals must be screened for cardiac arrhythmias or medications that could potentially precipitate an arrhythmia. Phenol can also have renal and hepatic toxicities.

The likelihood and potential severity of adverse events increases as the strength of the chemicals and depth of peels increases. With deep chemical peels, there is the potential for long-term pigmentary disturbances (ie, areas of hypopigmentation), and selection of Individuals willing to always wear makeup is advised. Moreover, chemical peels reduce melanin protection, so Individuals must use protective sunscreen for 9 to 12 months after a medium- to deep-facial peel.

Applications

Chemical peels are a potential treatment option for actinic keratoses and moderate-to-severe acne. Actinic keratoses are common skin lesions associated with extended exposure to the sun, with an estimated prevalence in the United States of 11% to 26%.³ These lesions are generally considered to be a precursor of squamous cell carcinoma.⁴ The risk of progression to invasive squamous cell carcinoma is unclear, but estimates vary from 0.1% to 20%.³ For Individuals with multiple actinic keratoses, the risk of developing invasive squamous cell carcinoma is estimated as being between 0.15% and 80%. Treatment options include watchful waiting, medication treatment, cryosurgery, surgical resection.

Acne vulgaris is the most common skin condition among adolescents, affecting an estimated 80% of teenagers aged 13 to 18 years old.⁵ Acne, particularly moderate-to-severe manifestations, can cause psychologic distress including low self-esteem, depression, and anxiety. There are a variety of oral and topical treatments for acne.

Regulatory Status:

U.S. Food and Drug Administration (FDA) clearance or approval of chemical agents used in peeling may not be relevant because these agents are prepared in-office, may have predated FDA approval, and/or may be considered cosmetic ingredients.

Medical Policy Statement

The safety and effectiveness of dermal chemical peels have been established in specific situations and may be considered a useful therapeutic option when indicated.

Inclusionary and Exclusionary Guidelines

Note: Requests for chemical peels should be carefully evaluated to determine if the request is primarily cosmetic in nature.

Inclusions:

Chemical peels performed in a 12 month period are appropriate as follows:

- Dermal (medium and deep) chemical peels, up to 4 times in a 12 month period, used to treat individuals with numerous (>10) actinic keratoses or other premalignant skin lesions
- Epidermal (superficial) peels, up to 6 times in a 12 month period, to treat active acne in individuals who have failed other therapy

Exclusions:

Chemical peels are considered cosmetic when used to treat:

- Photoaged skin
 - Wrinkles
 - Acne scarring
 - Chemical peel solutions and hydrating agents that do not require physician supervision for application
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CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established codes:

15788

15789

15792

15793

17360

Other codes (investigational, not medically necessary, etc.):

N/A

Rationale

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function, including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

ACTINIC KERATOSES

Clinical Context and Therapy Purpose

The purpose of dermal chemical peels for individuals who have actinic keratosis is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with actinic keratosis.

Interventions

The therapy being considered is dermal chemical peels.

Comparators

The following therapies are currently being used to treat actinic keratosis: watchful waiting, medication treatment, cryosurgery, surgical resection, and photodynamic therapy.

Outcomes

The general outcomes of interest are destroying actinic keratosis, the durability of this effect, the development of cancerous lesions, quality of life, and the harms of associated treatment-related morbidities.

The relevant follow-up is within weeks for the efficacy of treatment and years for the occurrence of cancerous lesions.

Study Selection Criteria

Methodologically credible studies for the indications within this review were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

REVIEW OF EVIDENCE

Systematic Reviews

Steeb et al (2020) conducted a systematic review and meta-analysis assessing the efficacy and safety of chemical peels for the treatment of actinic keratosis.⁶ A summary of the 8 trials included in the systematic review is shown in Table 1. This includes 4 RCTs, 2 non-randomized controlled trials, and 2 single-arm studies. Characteristics and results of the systematic review are summarized in Tables 2 and 3. Data analysis and interpretation of results were challenged by the presence of multiple study designs and the investigation of multiple distinct comparisons. The studies included in the review were at a high risk for selection bias as only 1 study clearly described the generation of a random sequence and performed allocation concealment. None of the patients in the studies were blinded; blinding of the outcome assessor was described in 1 study. Additionally, the chosen efficacy outcomes refer to short-term clearance rates but may not reflect long-term results. Overall, the authors concluded that additional high-quality studies and a standardization of peeling protocols were warranted in order to appropriately determine the value of chemical peeling as a treatment for actinic keratoses.

Table 1. Trials Included in a Systematic Review and Meta-Analysis of Chemical Peels for Actinic Keratosis

Trials	Systematic Review
	Steeb et al (2020) ⁶ .
Alfaro et al (2012) ⁷ .	•
Di Nuzzo et al (2015) ⁸ .	•
Holzer et al (2017) ⁹ .	•
Kaminaka et al (2009) ¹⁰ .	•
Lawrence et al (1995) ¹¹ .	•
Marrero et al (1998) ¹² .	•
Sandoval Osses et al (2010) ¹³ .	•
Sumita et al (2018) ¹⁴ .	•

Table 2. Summary of a Systematic Review and Meta-Analysis of Chemical Peels for Actinic Keratosis

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Steeb et al (2020) ⁶ .	Until August 2019	8	Adults with a clinical or histopathological diagnosis of actinic keratosis	170 (13 to 32)	4 RCTs 2 non-randomized controlled trials 2 single-arm studies	NR

NR: not reported; RCT: randomized controlled trial.

Table 3. Results of a Systematic Review and Meta-Analysis of Chemical Peels for Actinic Keratosis

Study	Clearance Rate	Lesion-Specific Clearance	Mean Lesion Reduction Rate per Patient	Treatment-Related Pain (VAS)
Steeb et al (2020) ⁶ .				
TCA vs. PDT (n = 2 studies)				
Crude rate	0% (0/13) vs 15.4% (2/13) ^a	66.1% (80/121) vs 82.1% (101/123) 60.5% (214/354) vs 82.6% (317/384)	65.9 ± 12.6 vs 81.9 ± 12 51.1 ± 28.7 vs 78.7 ± 26.2	7.31 ± 1.55 vs 8.38 ± 1.56 5.1 ± 2.6 vs 7.5 ± 2.3
Effect estimate	RR 0.20 (95% CI, 0.01 to 3.80) ^a	RR 0.75 (95% CI, 0.69 to 0.82)	MD -20.48 (95% CI, -31.55 to -9.41)	MD -1.71 (95% CI, -3.02 to -0.41)
TCA + Jessner's solution vs. 5-FU (n = 2 studies)				
Crude rate	15% (3/20) vs 35% (7/20) 13.3% (2/15) vs 46.7% (7/15)	81.7% (201/246) vs 89% (202/227)	79.2 ± 19.5 vs 89.6 ± 17.4	NR
Effect estimate	RR 0.36 (95% CI, 0.14 to 0.90)	RR 0.92 (95% CI, 0.85 to 0.99) ^a	MD -10.4 (95% CI, -23.63 to 2.83) ^a	NR
GA + 5-FU vs. GA (n = 1 study)				
Crude rate	22.2% (4/18) vs 0% (0/18)	92.7% (217/234) vs 15.8% (39/247)	92.1 ± 5.5 vs 17.4 ± 8.7	NR
Effect estimate	RR 9.0 (95% CI, 0.52 to 155.86)	RR 5.87 (95% CI, 4.39 to 7.85)	MD 74.7 (95% CI, 69.95 to 79.45)	NR
Phenol peeling (n = 1 study)				
Crude rate	90.62% (29/32)	NR	NR	NR
5-FU + GA (n = 1 study)				
Crude rate	30% (6/20)	92% (322/350)	NR	NR

^a Only 1 study reported data for this outcome.

5-FU: 5-fluorouracil; CI confidence interval; GA: glycolic acid; MD: mean difference; NR: not reported; PDT: photodynamic therapy; RR: risk ratio; TCA: trichloroacetic acid; VAS: visual analogue scale.

Section Summary: Actinic Keratoses

The evidence consists of a systematic review involving 8 studies – 4 RCTs, 2 non-randomized controlled trials, and 2 single-arm studies. Data analysis and interpretation of results were challenged by the high risk of bias of the primary studies, their imprecision, the variability of their peeling application protocols, and their focus on short-term clearance rates. Additional controlled studies, preferably randomized, are needed to determine the effect of chemical peels on the net health outcome in Individuals with actinic keratoses.

MODERATE-TO-SEVERE ACTIVE ACNE

Clinical Context and Therapy Purpose

The purpose of epidermal chemical peels for individuals who have moderate-to-severe active acne is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with moderate-to-severe active acne.

Interventions

The therapy being considered is epidermal chemical peels.

Comparators

The following therapies are currently being used to treat active acne: topical or oral medications.

Outcomes

The general outcomes of interest are the resolution of severe acne and the harms of treatment-related morbidities.

The relevant follow-up is within weeks for the efficacy of treatment.

Study Selection Criteria

As described under the first indication.

REVIEW OF EVIDENCE

Randomized Controlled Trials

RCTs comparing chemical peels to topical or oral medications for moderate-to-severe acne were not identified; the majority of studies evaluating the use of chemical peels for acne were in patients with mild-to-moderate disease. Of note, Kaminaka et al (2014) conducted a double-blinded, placebo-controlled randomized trial using a split-face design in Japan that evaluated 26 patients with moderate-to-severe facial acne.¹⁵ Patients with moderate acne had 6 to 20 inflammatory lesions and up to 20 noninflammatory lesions; patients with severe acne had 21 to 50 inflammatory lesions. Failure of previous treatments was not an explicit inclusion criterion. Patients had to undergo a washout period of 2 months before study participation during which they could not use topical or oral antibiotics, retinoids, or corticosteroids. Participants then received a chemical peel treatment on a randomly selected side of the face,

and a placebo peel on the other side of their face. Both treatments used the same pH acid gel vehicle (pH, 2.0) and the active treatment was a glycolic acid 40% peel. Treatments were given every 2 weeks for a total of 5 applications, and follow-up occurred 2 weeks after the last session (ie, at 10-week follow-up). The overall therapeutic effect was judged by a blinded dermatologist as excellent or good for 23 (92%) of the chemical peel sides and 10 (40%) of the placebo sides; the difference between groups was statistically significant ($p < .01$). Moreover, there were statistically significant reductions in inflammatory lesions, and total lesion counts at each 2-week assessment and at the final 10-week assessment. No serious side effects or systemic adverse events were reported.

Section Summary: Moderate-to-Severe Active Acne

No RCTs comparing chemical peels to topical or oral medications in patients with moderate-to-severe acne were found. One placebo-controlled randomized trial was identified using a split-faced design with 26 patients who had moderate-to-severe acne. Outcomes (eg, overall therapeutic effect) were significantly better in the chemical peel group. However, this trial testing a single chemical peel protocol in a relatively small number of patients provides insufficient evidence from which to draw conclusions about the safety and efficacy of chemical peels for treating active moderate-to-severe acne.

SUMMARY OF EVIDENCE

For individuals who have actinic keratoses who receive dermal chemical peels, the evidence consists of a systematic review involving 8 studies – 4 randomized controlled trials (RCTs), 2 non-randomized controlled trials, and 2 single-arm studies. Relevant outcomes are symptoms, morbid events, quality of life, and treatment-related morbidity. Data analysis and interpretation of results were challenged by the high risk of bias of the primary studies, their imprecision, the variability of their peeling application protocols, and their focus on short-term clearance rates. Additional controlled studies, preferably randomized, are needed.

For individuals who have moderate-to-severe active acne who receive epidermal chemical peels, the evidence includes an RCT. Relevant outcomes are symptoms, morbid events, quality of life, and treatment-related morbidity. Results from the single, small, randomized, placebo-controlled, split-faced trial found greater efficacy with active treatment than with placebo. However, no studies were identified comparing chemical peel agents with conventional acne treatment.

SUPPLEMENTAL INFORMATION

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Clinical Input Received through Physician Specialty Societies and Academic Medical Centers

In response to requests, the Blue Cross Blue Shield Association received input through 3 Physician Specialty Societies and 4 Academic Medical Centers while their policy was under review in 2010. Input was consistently in agreement with the medically necessary indications for dermal and epidermal chemical peels. Several reviewers supported use of chemical peels for post-acne scarring.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Academy of Dermatology

In 2016, the American Academy of Dermatology (AAD) published guidelines on the management of acne vulgaris, which give a B recommendation based on level II and III evidence for the use of chemical peels for acne, with the following statement on chemical peels¹⁶:

"Studies exist suggesting that chemical peels may improve acne. However, large, multicenter, double-blinded control trials comparing peels to placebo and comparing different peels are lacking. Glycolic acid and salicylic acid chemical peels may be helpful for noninflammatory (comedonal) lesions. However, multiple treatments are needed and the results are not long-lasting. In the opinion of the work group, chemical peels may result in mild improvement in comedonal acne."

In 2021, the AAD published guidelines on the management of actinic keratosis, which gave a conditional recommendation based on moderate quality of evidence for the use of specific chemical peels for actinic keratosis.¹⁷ The recommendation stated: "For patients with AKs [actinic keratosis], we conditionally recommend treatment with ALA [aminolevulinic acid]-red light PDT [photodynamic therapy] over trichloroacetic acid peel."

American Society for Dermatologic Surgery

In 2017, the American Society for Dermatologic Surgery published recommendations on the use of several skin treatments following a course of isotretinoin, a treatment for severe cystic acne.¹⁷ Previously, a number of cosmetic skin treatments, including chemical peels, were discouraged for 6 months after the use of isotretinoin. These 2017 guidelines evaluated various treatments in the context of scarring and found that superficial chemical peels were safe as a treatment either concurrent with isotretinoin or within 6 months of its discontinuation. The lack of data on medium or deep chemical peels did not permit the Society to make a recommendation on those treatments.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 4.

Table 4. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT04429308	PDT Versus the Combination of Jessner's Solution and 35% TCA for Treatment of Actinic Keratoses on Upper Extremities: A Randomized Controlled Split-arm Trial	60	December 2025

NCT: national clinical trial.

Government Regulations

National:

National Coverage Determination (NCD) for Treatment of Actinic Keratosis (250.4) Effective date of this version: 11/26/2001

Actinic Keratosis, also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have the potential to become a skin cancer.

Various options exist for treating actinic keratosis. Clinicians should select an appropriate treatment based on the patient's medical history, the lesion's characteristics, and on the patient's preference for a specific treatment. Commonly performed treatments for actinic keratosis include cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for actinic keratosis include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy. An alternative approach to treating actinic keratosis is to observe the lesions over time and remove them only if they exhibit specific clinical features suggesting possible transformation to invasive squamous cell carcinoma.

Medicare covers the destruction of actinic keratoses without restrictions based on lesion or patient characteristics.

Local:

There is no local coverage determination on this topic.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

Ultraviolet Light Therapy Delivery Devices for Home Use (BCN only – Retired)
Photodynamic Therapy for Actinic Keratosis (Retired)

References

1. Habif TP. *Clinical Dermatology* 5th edition. Philadelphia, PA: Mosby/Elsevier; 2010.
2. Cummings CW, Haughey BH, Thomas JR et al. *Otolaryngology: Head and Neck Surgery*, 4th edition. St Louis, MO: Mosby; 2005.
3. Costa C, Scalvenzi M, Ayala F, et al. How to treat actinic keratosis? An update. *J Dermatol Case Rep.* Jun 30 2015;9(2):29-35. PMID 26236409
4. Padilla RS, Sebastian S, Jiang Z, et al. Gene expression patterns of normal human skin, actinic keratosis, and squamous cell carcinoma: a spectrum of disease progression. *Arch Dermatol.* Mar 2010;146(3):288-293. PMID 20231500
5. Purdy S, de Berker D. Acne vulgaris. *BMJ Clin Evid.* Jan 05 2011;2011. PMID 21477388
6. Steeb T, Koch EAT, Wessely A, et al. Chemical peelings for the treatment of actinic keratosis: a systematic review and metaanalysis. *J Eur Acad Dermatol Venereol.* Aug 03 2020. PMID 32745330
7. Alfaro OL, Alcalá PD, Navarrete FG, et al. Effectiveness of Jessner's solution plus 35% trichloroacetic acid versus 5% 5- fluorouracil on multiple facial actinic keratosis. *Dermatol Rev Mex.* 2012;56:38-46.
8. Di Nuzzo S, Cortelazzi C, Boccaletti V, et al. Comparative study of trichloroacetic acid vs. photodynamic therapy with topical 5-aminolevulinic acid for actinic keratosis of the scalp. *Photodermatol Photoimmunol Photomed.* Sep 2015; 31(5): 233-8. PMID 25660106
9. Holzer G, Pinkowicz A, Radakovic S, et al. Randomized controlled trial comparing 35% trichloroacetic acid peel and 5-aminolaevulinic acid photodynamic therapy for treating multiple actinic keratosis. *Br J Dermatol.* May 2017; 176(5): 1155-1161. PMID 28012181
10. Kaminaka C, Yamamoto Y, Yonei N, et al. Phenol peels as a novel therapeutic approach for actinic keratosis and Bowen disease: prospective pilot trial with assessment of clinical, histologic, and immunohistochemical correlations. *J Am Acad Dermatol.* Apr 2009;60(4):615-625. PMID 19293009
11. Lawrence N, Cox SE, Cockerell CJ, et al. A comparison of the efficacy and safety of Jessner's solution and 35% trichloroacetic acid vs 5% fluorouracil in the treatment of widespread facial actinic keratoses. *Arch Dermatol.* Feb 1995;131(2):176-181. PMID 7857114
12. Marrero GM, Katz BE. The new fluor-hydroxy pulse peel. A combination of 5-fluorouracil and glycolic acid. *Dermatol Surg.* Sep 1998; 24(9): 973-8. PMID 9754085
13. Sandoval Osses M, Garcia-Huidobro Ramirez I, Molgo Novell M. Safety and effectiveness of the association of 5-fluorouracil and glycolic acid peeling for the treatment of multiple actinic keratoses. *Piel.* 2010;25:4-8.
14. Sumita JM, Miot HA, Soares JLM, et al. Tretinoin (0.05% cream vs. 5% peel) for photoaging and field cancerization of the forearms: randomized, evaluator-blinded, clinical trial. *J Eur Acad Dermatol Venereol.* Oct 2018; 32(10): 1819-1826. PMID 29704456
15. Kaminaka C, Uede M, Matsunaka H, et al. Clinical evaluation of glycolic acid chemical peeling in patients with acne vulgaris: a randomized, double-blind, placebo-controlled, split-face comparative study. *Dermatol Surg.* Mar 2014; 40(3): 314-22. PMID 24447110
16. Zaenglein AL, Pathy AL, Schlosser BJ, et al. Guidelines of care for the management of acne vulgaris. *J Am Acad Dermatol.* May 2016; 74(5): 945-73.e33. PMID 26897386
17. Eisen DB, Asgari MM, Bennett DD, et al. Guidelines of care for the management of actinic keratosis. *J Am Acad Dermatol.* Oct 2021; 85(4): e209-e233. PMID 33820677
18. Waldman A, Bolotin D, Arndt KA, et al. ASDS Guidelines Task Force: Consensus Recommendations Regarding the Safety of Lasers, Dermabrasion, Chemical Peels,

Energy Devices, and Skin Surgery During and After Isotretinoin Use. *Dermatol Surg.* Oct 2017; 43(10): 1249-1262. PMID 28498204

19. Centers for Medicare and Medicaid. National Coverage Determination (NCD) for Treatment of Actinic Keratosis (250.4), 11/26/2001 <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=129&ncdver=1&bc=AgAAQAAAAAAAA&> Accessed 3/16/24.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 3/16/24, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
2/12/02	2/12/02	2/12/02	Joint policy established
9/7/04	9/7/04	8/27/04	Routine maintenance
12/30/05	12/30/05	12/05/05	Routine maintenance
3/1/07	11/19/06	11/19/06	Routine maintenance
3/1/08	12/11/07	11/18/07	Established
3/1/09	N/A	12/21/08	Routine maintenance
5/1/09	2/10/09	2/10/09	Routine maintenance
1/01/12	10/11/11	11/9/11	Routine maintenance
5/1/13	2/19/13	3/4/13	Routine maintenance; references and rationale updated.
3/1/14	12/10/13	1/6/14	Routine maintenance
11/1/15	8/24/15	9/14/15	Routine maintenance
11/1/16	8/16/16	8/16/16	Routine maintenance
11/1/17	8/15/17	8/15/17	Routine maintenance
9/1/18	6/19/18	6/19/18	Routine maintenance
9/1/19	6/18/19		Routine maintenance
9/1/20	6/16/20		Routine maintenance
9/1/21	6/15/21		Routine maintenance; ref 6, 7, 8, 9, 12, 13, 14 added.
9/1/22	6/21/22		Routine maintenance
9/1/23	6/13/23		Routine maintenance (jf) Vendor Managed: NA
9/1/24	6/11/24		Routine maintenance (jf) Vendor Managed: NA Add Ref: 17

Next Review Date: 2nd Qtr, 2025

**BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: CHEMICAL PEELS**

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Policy criteria apply.
BCNA (Medicare Advantage)	See Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.