8.01.16	Chemical Peels		
Original Policy Date:	August 29, 2014	**Effective Date:**	February 1, 2025
Section:	8.0 Therapy	**Page:**	Page 1 of 12

Policy Statement

I. Dermal chemical peels may be considered **medically necessary** used to treat individuals with numerous (greater than 10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical.

II. Epidermal chemical peels may be considered **medically necessary** when used to treat individuals with active acne that has failed a trial of topical and/or oral antibiotic acne therapy. In this setting, superficial chemical peels with 40% to 70% alpha hydroxy acids are used as a comedolytic therapy. (Alpha-hydroxy acids can also be used in lower concentrations [8%] without the supervision of a provider.)

III. Epidermal chemical peels are considered **investigational** and cosmetic when used to treat **any of** the following:
   A. Acne scarring or dermal peels used to treat end-state acne scarring
   B. Photoaged skin
   C. Wrinkles

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Requests for all chemical peels should be carefully evaluated to determine whether the rationale is primarily cosmetic. Epidermal peels would be considered medically necessary in individuals with active acne who have failed other therapy because active severe acne may lead to acne scarring and may be psychologically painful leading to low self-esteem, depression, and anxiety. Dermal peels would be considered medically necessary in individuals with multiple actinic keratoses because these premalignant lesions may warrant destruction or removal as an alternative to watchful waiting. Other applications of chemical peels, including treatment of photoaged skin, wrinkles, and acne scarring, are considered cosmetic.

Coding
See the Codes table for details.

Description

A chemical peel is a controlled removal of various layers of the skin with the use of a chemical agent. The most common use of chemical peeling is the treatment of photoaged skin. Chemical peeling has also been used for other conditions, including actinic keratoses, active acne, and acne scarring.

Related Policies

- Dermatologic Applications of Photodynamic Therapy

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract

language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

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.

Rationale

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 the 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, the 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, patients 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 (e.g., 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 new, erythematous epithelium. Individuals are advised to wait at least 3 months before resuming skincare services (e.g., 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 patients 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 patients 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 increase as the strength of the chemicals and the depth of peels increases. With deep chemical peels, there is the potential for long-term pigmentary disturbances (i.e., areas of hypopigmentation), and selection of individuals willing to always wear makeup is advised. Moreover, chemical peels reduce melanin protection, so patients 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 U.S. 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 patients 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, and 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.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function, including benefits and harms. Every clinical condition has specific outcomes that are important to patients and 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 a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and 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.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA

(Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

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, QOL, 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 because only one 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 one 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)				

Study	Clearance Rate	Lesion-Specific Clearance	Mean Lesion Reduction Rate per Patient	Treatment-Related Pain (VAS)
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 patients 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
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

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-blind, 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 (i.e., 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 (e.g., 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.

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 From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2010 Input

In response to requests, input was received from 3 physician specialty societies and 4 academic medical centers while this 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 the 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 2024, the American Academy of Dermatology (AAD) published guidelines on the management of acne vulgaris, which included the following statement on chemical peels[16,] :

> "Available evidence is insufficient to develop a recommendation on the use of...chemical peels (including glycolic acid, trichloroacetic acid, salicylic acid, Jessner's solution, or mandelic acid)...for the treatment of 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.[18,] 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.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

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
Ongoing			
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.

References

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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): 288-93. PMID 20231500
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7. Alfaro OL, Alcala 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
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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. Reynolds RV, Yeung H, Cheng CE, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. May 2024; 90(5): 1006.e1-1006.e30. PMID 38300170
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

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Documented trial of topical and/or oral antibiotic treatment and response
  - Reason for chemical peel
  - Severity/number of lesions

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	15788	Chemical peel, facial; epidermal
	15789	Chemical peel, facial; dermal
	15792	Chemical peel, nonfacial; epidermal
	15793	Chemical peel, nonfacial; dermal
	17360	Chemical exfoliation for acne (e.g., acne paste, acid)
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
08/29/2014	BCBSA Medical Policy adoption
03/30/2015	Policy clarification
12/04/2015	Policy revision with position change
02/01/2017	Policy revision without position change
02/01/2018	Policy revision without position change
03/01/2019	Policy revision without position change
03/01/2020	Annual review. No change to policy statement. Literature review updated.
03/01/2024	Policy reactivated. Previously archived from 09/01/2020 to 02/29/2024.
02/01/2025	Annual review. Policy statement, guidelines and literature review updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE	**AFTER** Blue font: Verbiage Changes/Additions
Chemical Peels 8.01.16 **Policy Statement:** I. Dermal chemical peels may be considered **medically necessary** when used to treat individuals with numerous (greater than 10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical. II. Epidermal chemical peels may be considered **medically necessary** when used to treat individuals with active acne that has failed a trial of topical and/or oral antibiotic acne therapy. In this setting, superficial chemical peels with 40% to 70% alpha hydroxy acids are used as a comedolytic therapy. (Alpha-hydroxy acids can also be used in lower concentrations [8%] without the supervision of a provider.) III. Epidermal chemical peels are considered **investigational** and cosmetic when used to treat **any of** the following: A. Acne scarring or dermal peels B. Photoaged skin C. Wrinkles	**Chemical Peels 8.01.16** **Policy Statement:** I. Dermal chemical peels may be considered **medically necessary** used to treat individuals with numerous (greater than 10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical. **II.** Epidermal chemical peels may be considered **medically necessary** when used to treat individuals with active acne that has failed a trial of topical and/or oral antibiotic acne therapy. In this setting, superficial chemical peels with 40% to 70% alpha hydroxy acids are used as a comedolytic therapy. (Alpha-hydroxy acids can also be used in lower concentrations [8%] without the supervision of a provider.) III. Epidermal chemical peels are considered **investigational** and cosmetic when used to treat **any of** the following: A. Acne scarring or dermal peels used to treat end-state acne scarring B. Photoaged skin C. Wrinkles