



Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

# Chemical Peels

**Policy Number:** 8.01.16

**Origination:** 11/2015

**Last Review:** 11/2018

**Next Review:** 11/2019

## **Policy**

Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for Chemical Peels when it is determined to be medically necessary because the criteria shown below are met.

Note: This is a procedure that may be excluded in some contracts. Verify benefits prior to review for Medical Necessity.

## **When Policy Topic is covered**

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

Epidermal chemical peels used to treat patients with active acne that has failed a trial of topical and/or oral antibiotic acne therapy are considered **medically necessary**. 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 physician.)

## **When Policy Topic is not covered**

Epidermal chemical peels used to treat photoaged skin, wrinkles, or acne scarring or dermal peels used to treat end-state acne scarring are considered **cosmetic**.

## **Considerations**

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 patients 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 patients 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.

## Description of Procedure or Service

Populations	Interventions	Comparators	Outcomes
Individuals: <ul style="list-style-type: none"> <li>▪ With actinic keratoses</li> </ul>	Interventions of interest are: <ul style="list-style-type: none"> <li>▪ Dermal chemical peels</li> </ul>	Comparators of interest are: <ul style="list-style-type: none"> <li>▪ Watchful waiting</li> <li>▪ Topical or oral medications</li> <li>▪ Photodynamic therapy</li> <li>▪ Cryosurgery</li> <li>▪ Surgical resection</li> </ul>	Relevant outcomes include: <ul style="list-style-type: none"> <li>▪ Symptoms</li> <li>▪ Morbid events</li> <li>▪ Quality of life</li> <li>▪ Treatment-related morbidity</li> </ul>
Individuals: <ul style="list-style-type: none"> <li>▪ With moderate-to-severe active acne</li> </ul>	Interventions of interest are: <ul style="list-style-type: none"> <li>▪ Epidermal chemical peels</li> </ul>	Comparators of interest are: <ul style="list-style-type: none"> <li>▪ Topical or oral medications</li> </ul>	Relevant outcomes include: <ul style="list-style-type: none"> <li>▪ Symptoms</li> <li>▪ Morbid events</li> <li>▪ Quality of life</li> <li>▪ Treatment-related morbidity</li> </ul>

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

For individuals who have actinic keratoses who receive dermal chemical peels, the evidence includes a nonrandomized split-face study and case series. Relevant outcomes are symptoms, morbid events, quality of life, and treatment-related morbidity. The split-face study found similar outcomes after a single chemical peel or after 3 weeks of treatment with fluorouracil cream 5% in 15 patients. A case series found high response rates and low recurrence rates at 1 year in patients with actinic keratoses treated with phenol peels. Additional controlled studies, preferably randomized, are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have moderate-to-severe active acne who receive epidermal chemical peels, the evidence includes randomized controlled trials (RCTs). Relevant outcomes are symptoms, morbid events, quality of life, and treatment-related morbidity. One small randomized trial was placebo-controlled; it found greater efficacy with active treatment than with placebo. Several RCTs comparing chemical peel agents in patients with acne have generally reported comparable improvements with the types of chemical peels studied. However, no studies were identified comparing chemical peel agents with conventional acne treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained in 2010 supported the use of chemical peels for treating multiple actinic keratoses and as second-line treatment of active moderate-to-severe acne.

## Background

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 patients. Potential local complications include scarring, infection, hypopigmentation, hyperpigmentation, activation of herpes simplex, and toxic shock syndrome.<sup>1</sup>

Chemical peels are often categorized according to 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 in 2005 by Cummings et al<sup>2</sup> and others, is as follows.

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 a total of 6 to 8 peels performed weekly or biweekly.

Medium-depth peels (dermal peels) extend into the epidermis to the papillary dermis. These 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 a high rate of complications such as pigmentary changes and 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. Patients are advised to wait at least 3 months before resuming skin care services such as superficial chemical peels, and repeat medium-depth chemical peels should not be performed for at least 1 year.

Deep chemical peels (another type of dermal peel) penetrate the midreticular dermis and are 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 Septisol (hexachlorophene), 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 effects 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 patients 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.

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%.<sup>(3)</sup> These lesions are generally considered to be a precursor of squamous cell carcinoma (SCC).<sup>(4)</sup> The risk of progression to invasive SCC is unclear, but estimates vary from 0.1% to 20%.<sup>(3)</sup> For patients with multiple actinic keratoses, the risk of developing invasive SCC 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 13- to 18-year olds.<sup>(5)</sup> 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.

## **Rationale**

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The evidence review was created in April 1998. It has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through November 1, 2017.

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 patients 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 one 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. The key literature is described below.

### **Actinic Keratoses**

Evaluating the effect of using chemical peels on patients with actinic keratosis, compared with alternatives such as watchful waiting, topical or oral medications, destructive treatments, or photodynamic therapy, would ideally include well-controlled comparative studies, such as RCTs with follow-up to compare outcomes such as occurrence of malignancy and treatment-related morbidity. Alternatively, comparison of robust observational studies may help to demonstrate the comparative effectiveness of treatment options by showing the benefit in destroying actinic keratosis, the durability of this effect, and the harms of associated treatment-related morbidities.

RCTs evaluating chemical peels for treatment of actinic keratoses were not identified. One nonrandomized split-face study was identified. This 1995 trial by Lawrence et al evaluated 15 male patients with multiple facial actinic keratoses in similar numbers on both sides of the face.<sup>6</sup> Patients were treated on the left side with a single application of Jessner solution plus trichloroacetic acid 35% and on the right side with fluorouracil cream 5% twice daily for 3 weeks. The efficacy of both treatments was similar. The difference in the number of actinic keratoses on the left versus right side of the face was not statistically significant at 6 or 12 months ( $p > 0.01$ ). Both treatments were associated with nonserious adverse events. On the chemical peel side of the face, patients developed erythema and mild desquamation lasting an average of 10 days in all but 1 patient, for whom the adverse event lasted 3 months. On the fluorouracil cream side of the face, there was erythema, scaling, erosion, and crusting; these adverse events persisted an additional 2 to 3 weeks beyond 3-week treatment period.

Kaminaka et al (2009) reported on a prospective case series from Japan that included 46 patients, 32 with actinic keratoses and 14 with Bowen disease.<sup>7</sup> There was no minimum number of actinic keratoses required for inclusion; ie, the study did not specifically address the treatment of multiple actinic keratoses. Patients received peels with 100% pure phenol applied locally to the lesions once a month for a maximum of 8 months (or less than 8 months if a complete response was achieved sooner). Biopsies were performed on all lesions before and at the end of therapy. Twenty-nine (91%) of the 32 patients with actinic keratoses achieved a complete response (defined as an undetectable lesion at least 1 month after the last phenol application). The average number of treatments for patients with actinic keratoses was 2.9. Ten (83%) of the 12 patients with Bowen disease had a complete response, and the average number of treatments in this group was 5.5. All patients were followed for at least 1 year after treatment (median follow-up, 2.8 years). By the 1-year follow-up, 2 (4.3%) of 46 patients, one with actinic

keratoses and one with Bowen disease, had experienced recurrences. No systemic adverse events were reported. The study lacked a control group and enrolled few subjects, especially in the subset of patients with Bowen disease.

Older review articles have suggested that chemical peels might be appropriate when there are numerous lesions (ie,  $\geq 10$ ), making treatment of the individual lesions impractical, and when treatment constitutes a full-thickness necrosis of the epidermis, which is considered curative.<sup>8,9</sup>

### **Section Summary: Actinic Keratoses**

The evidence consists of a nonrandomized split-face study and case series. The split-face trial found similar outcomes after a single chemical peel and after 3 weeks of treatment with fluorouracil cream 5% in 15 patients. A case series found high response rates and low recurrence rates at 1 year in patients with actinic keratoses treated with phenol peels. Additional controlled studies, preferably randomized, are needed to determine the effect of chemical peels on the net health outcome in patients with actinic keratoses.

### **Active Acne**

Evaluating the effect of chemical peels on active acne compared with alternatives (eg, topical or oral medications) would ideally include well-controlled comparative studies, such as RCTs with follow-up for outcomes such as resolution of severe acne and occurrence of disease-related psychologic symptoms (eg, depression, anxiety). Alternatively, comparison of robust observational studies may demonstrate the effectiveness of treatment options by showing the benefit in reducing the occurrence of severe acne lesions. In addition, studies that have demonstrated the effects of severe acne on the psychological symptoms and the impact of effective acne treatment to reduce those symptoms may be combined using a chain of evidence to link information regarding the effect of treatments such as chemical peels on health outcomes for patients with active acne.

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.<sup>10</sup> 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 ( $p < 0.01$ ). 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.

Several RCTs have compared 2 types of chemical peels.<sup>11-15</sup> Most were conducted outside of the United States and used split-faced designs. Among the trials comparing 2 chemical peel interventions, salicylic acid was used as the chemical peel agent in all but 1 trial, which was conducted by Ilknur et al (2010) in Turkey.<sup>12</sup>

A single-blind RCT by Ilknur et al compared glycolic acid peels with amino fruit peels.<sup>12</sup> The trial included 30 patients with noninflamed lesions and superficial inflamed lesions, with acne grades 0.25 to 2 using Leeds criteria. Patients received 12 peels on the 2 halves of their faces at 2-week intervals (total, 6 months). Twenty-four (80%) of 30 patients completed the trial. The mean (standard deviation [SD]) number of noninflamed lesions on the glycolic acid side decreased from 49.1 (40.6) at baseline to 18.3 (12.9) at 6 months. The mean (SD) number of noninflamed lesions on the amino fruit acid side decreased from 45.6 (43.5) at baseline to 17.1 (14.2) at 6 months. The reduction in lesions did not differ significantly between groups. Findings were similar for the other primary outcome (number of superficial inflamed lesions). At 6 months, the number (SD) of inflamed lesions was 6.9 (5.2) on the glycolic acid side and 7.0 (7.3) on the amino fruit acid side ( $p>0.05$ ).

A 2011 RCT by Levesque et al in France compared salicylic acid peels with peels using a lipophilic hydroxy acid derivative of salicylic acid in 20 patients.<sup>11</sup> To be eligible, patients had to have at least 5 noninflammatory acne lesions on each side of the face and fewer than 30 inflammatory acne lesions on the entire face. Participants were required to stop using other acne medications before starting the chemical peel treatment. In this single-blind trial, patients received 1 treatment to 1 side of their face (selected randomly) and the other treatment to the other side. Treatments occurred every other week for a total of 6 peels. At the end of the treatment period, the reduction in the proportion of noninflammatory lesions was 55.6% on the lipophilic hydroxy acid side and 48.5% on the salicylic acid side; the difference between groups was not statistically significant ( $p=0.88$ ). The number of lesions decreased significantly between baseline and the end of treatment in both groups ( $p<0.001$ ). Both treatments were well tolerated (as assessed by a global tolerance scale); there was no significant difference between treatments in erythema ( $p=0.10$ ).

In 2017, Dayal et al in India published a parallel-group RCT comparing salicylic acid 30% peels with peels using Jessner solution in patients with mild-to-moderate facial acne.<sup>15</sup> Patients received 6 chemical peels using either solution; treatments were performed 2 weeks apart. At the end of the 12-week treatment period, the percent decrease in mean number of comedones was 53% in the salicylic acid group and 26% in the Jessner solution group ( $p=0.001$ ). However, there was no significant difference in the decrease in mean papule counts ( $p=0.87$ ) or mean pustule counts ( $p=0.57$ ) at 12 weeks. The mean Michaelson Acne Severity Score, which is based on the number of comedones, papules, and pustules, was

significantly better in the salicylic acid group at 12 weeks than in the Jessner solution group ( $p=0.002$ ). Both treatments were generally well tolerated. Postpeel burning and stinging was more common with salicylic acid and postpeel erythema was more common with the Jessner solution.

### **Section Summary: Active Acne**

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 acne. Several RCTs compared 2 chemical peel agents. None of the split-faced trials found significantly better outcomes with 1 agent over the other. One parallel-group RCT had mixed findings but greater efficacy with salicylic acid peels than with Jessner solution peels for some outcomes. None of the RCTs comparing 2 chemical peel protocols included a control group that received a different treatment; therefore, it is uncertain whether either type of peel was more effective than alternative approaches to treating acne.

### **Summary of Evidence**

For individuals who have actinic keratoses who receive dermal chemical peels, the evidence includes a nonrandomized split-face study and case series. Relevant outcomes are symptoms, morbid events, quality of life, and treatment-related morbidity. The split-face study found similar outcomes after a single chemical peel or after 3 weeks of treatment with fluorouracil cream 5% in 15 patients. A case series found high response rates and low recurrence rates at 1 year in patients with actinic keratoses treated with phenol peels. Additional controlled studies, preferably randomized, are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have moderate-to-severe active acne who receive epidermal chemical peels, the evidence includes randomized controlled trials. Relevant outcomes are symptoms, morbid events, quality of life, and treatment-related morbidity. One small randomized trial was placebo-controlled; it found greater efficacy with active treatment than with placebo. Several randomized controlled trials comparing chemical peel agents in patients with acne have reported similar improvements with the types of chemical peels studied. However, no studies were identified comparing chemical peel agents with conventional acne treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

### **Supplemental Information**

#### **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.

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 postacne scarring.

## **Practice Guidelines and Position Statements**

### **American Academy of Dermatology**

In 2016, the American Academy of Dermatology published guidelines on the management of acne vulgaris, which made the following statement on chemical peels<sup>16</sup>:

“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.”

### **American Society for Dermatologic Surgery**

The American Society for Dermatologic Surgery published recommendations in 2017 on the use of several skin treatments following a course of isotretinoin, a treatment for severe cystic acne.<sup>17</sup> 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**

A search of [ClinicalTrials.gov](http://ClinicalTrials.gov) in November 2017 did not identify any ongoing or unpublished trials that would likely influence this review.

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## **Billing Coding/Physician Documentation Information**

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- 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 (eg, acne paste, acid)

### **ICD-10 Codes**

- D48.5** Neoplasm of uncertain behavior of skin

- L57.0** Actinic keratosis
- L70.0** Acne vulgaris
- L70.1** Acne conglobata
- L70.9** Acne, unspecified

### **Additional Policy Key Words**

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N/A

### **Policy Implementation/Update Information**

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- 11/1/15 New Policy, considered medically necessary except for cosmetic reasons.
- 11/1/16 No policy statement changes.
- 11/1/17 No policy statement changes.
- 11/1/18 No policy statement changes.

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State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.