BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Nonpharmacologic Treatment of Rosacea
Corporate Medical Policy

File Name: Nonpharmacologic Treatment of Rosacea
File Code: 2.01.VT71
Origination: 08/2016
Last Review: 03/2022
Next Review: 03/2023
Effective Date: 10/01/2022 **(ARCHIVED)**

Description/Summary

Rosacea is a chronic, inflammatory skin condition without a known cure; the goal of treatment is symptom management. Nonpharmacologic treatments, including laser and light therapy, dermabrasion, and others, are proposed for patients who do not want to use or are unresponsive to pharmacologic therapy.

For individuals who have rosacea who receive nonpharmacologic treatment (e.g., laser therapy, light therapy, dermabrasion, others) the evidence includes several small randomized, split-face design-trials. Relevant outcomes are symptoms, change in disease status, and treatment-related morbidity. None of the randomized controlled trials (RCTs) included a comparison group of patients receiving a placebo or pharmacologic treatment and, therefore, these studies do not offer definitive evidence on the efficacy of nonpharmacologic treatment compared with alternative treatment options. There is a need for additional RCTs comparing nonpharmacologic treatments with placebo controls and with pharmacologic treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- Code Table & Instructions

When a service is considered investigational

Nonpharmacologic treatment of rosacea, including but not limited to laser and light therapy, dermabrasion, chemical peels, surgical debulking and electrosurgery, is considered **investigational**.

Reference Resources

1. BlueCross and BlueShield Association MPRM 2.01.71 Nonpharmacologic Treatment of Rosacea. Last Review January 2022.

Related Policies

Light Therapy for Psoriasis

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's

benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

08/2016	New Policy. Adopted BCBSA MPRM# 2.01.71
10/2017	Reviewed MPRM 2.01.71, updated references, added related policies section.
01/2019	Reviewed BCBSA MPRM 2.01.71, updated references, updated ICD-10-CM table policy statement remains unchanged.
03/2021	Updated references. No change to policy statement.
03/2022	Policy Archived. Codes 15780, 15781, 15782, 15783 removed from requiring prior approval also codes removed from investigational medical policy with diagnosis codes: L71.0, L71.1, L71.8, L71.9.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors Date Approved

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Chief Medical Officer

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Senior Medical Director

Attachment I
Code Table & Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be considered as medically necessary if medical necessity criteria have been met.			
CPT®	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	
CPT®	15781	Dermabrasion; segmental, face	
CPT®	15782	Dermabrasion; regional, other than Face	
CPT®	15783	Dermabrasion; superficial, any site (eg, tattoo removal)	