MASSACHUSETTS

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Medical Policy

Nonpharmacologic Treatment of Rosacea

Table of Contents

Policy Number: 462

BCBSA Reference Number: 2.01.71 (For Plans internal use only)
NCD/LCD: N/A

Related Policies

- Chemical Peels, #732
- Phototherapy: PUVA and UV-B, #059

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Excision and/or shaving of rhinophyma using a laser or other technique is considered **MEDICALLY NECESSARY** when there is documented evidence of bleeding, infection, or functional airway obstruction and it is reasonably likely the procedure will improve this condition.

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

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **not required**.
Commercial PPO and Indemnity	Prior authorization is **not required**.
Medicare HMO Blue℠	Prior authorization is **not required**.
Medicare PPO Blue℠	Prior authorization is **not required**.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following code to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
30120	Excision or surgical planing of skin of nose for rhinophyma

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT code above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

ICD-10 Diagnosis codes:	Code Description
L71.1	Rhinophyma

According to the policy statement above, the following CPT codes are considered investigational for the conditions listed for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions

17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm

Description

Rosacea

Rosacea is characterized by episodic erythema, edema, papules, pustules, and telangiectasia that occur primarily on the face but also present on the scalp, ears, neck, chest, and back. On occasion, rosacea may affect the eyes. Patients with rosacea tend to flush or blush easily. Because rosacea causes facial swelling and redness, it is easily confused with other skin conditions such as acne, skin allergy, and sunburn.

Rosacea mostly affects adults with fair skin between the ages of 20 and 60 years and is more common in women, but often is most severe in men. Rosacea is not life-threatening, but if not treated, it may lead to persistent erythema, telangiectasias, and rhinophyma (hyperplasia and nodular swelling and congestion of the skin of the nose). The etiology and pathogenesis of rosacea are unknown but may result from both genetic and environmental factors. Some theories on the causes of rosacea include blood vessel disorders, chronic *Helicobacter pylori* infection, Demodex folliculorum (mites), and immune system disorders.

While the clinical manifestations of rosacea do not usually impact the physical health status of the patient, psychological consequences from the most visually apparent symptoms (i.e., erythema, papules, pustules, telangiectasias) may impact quality of life. Rhinophyma, an end-stage form of chronic acne, has been associated with obstruction of nasal passages and basal cell carcinoma in rare, severe cases. The probability of developing nasal obstruction or basal or squamous cell carcinoma with rosacea is not sufficient to warrant the preventive removal of rhinophymatous tissue.

Treatment

Rosacea treatment can be effective in relieving signs and symptoms. Treatment may include oral and topical antibiotics, isotretinoin, b-blockers, alpha$_2$-adrenergic agonists (e.g., oxymetazoline, clonidine), and anti-inflammatories. Patients are also instructed on various self-care measures such as avoiding skin irritants and dietary items thought to exacerbate acute flare-ups.

Nonpharmacologic therapy has also been tried in patients who cannot tolerate or do not want to use pharmacologic treatments. To reduce visible blood vessels, treat rhinophyma, reduce redness, and improve appearance, various techniques have been used such as laser and light therapy, dermabrasion, chemical peels, surgical debulking, and electrosurgery. Various lasers used include low-powered electrical devices and vascular light lasers to remove telangiectasias, carbon dioxide lasers to remove unwanted tissue from rhinophyma and reshape the nose, and intense pulsed lights that generate multiple wavelengths to treat a broader spectrum of tissue.

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 as well as dermabrasion, which are the focus of this evidence review, are proposed for patients who do not want to use or are unresponsive to pharmacologic therapy.

Summary of Evidence

For individuals who have rosacea who receive nonpharmacologic treatment (e.g., laser therapy, light therapy, dermabrasion), the evidence includes systematic reviews and several small, randomized, split-face design trials. Relevant outcomes are symptoms, change in disease status, and treatment-related morbidity. The systematic reviews reported favorable effects on erythema and telangiectasia with several

laser types, including intense pulsed light (IPL), pulsed dye lasers, and neodymium-doped yttrium aluminum garnet (Nd:YAG) lasers. However, the systematic reviews did not pool results from individual studies and the studies differed in the specific lasers being compared. Overall, the systematic review results were insufficient to establish whether any laser type is more effective and safer than others. The randomized controlled trials (RCTs) evaluated laser and light therapy. One RCT compared combination laser and pharmacologic therapy with pharmacologic therapy alone, but the lack of an arm evaluating laser therapy alone does not allow a direct assessment on the efficacy of laser or light treatment compared with alternative treatments. No trials assessing other nonpharmacologic treatments were identified. There is a need for RCTs that compare both nonpharmacologic treatments with placebo controls and with pharmacologic treatments. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
2/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
2/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
2/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2018	Annual policy review. New references added.
1/2017	Annual policy review. New references added.
1/2016	Annual policy review. New references added.
10/2015	Ongoing medically necessary and investigational indications transferred from medical policy #068, Plastic Surgery. 10/1/2015.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

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