08.01.07 Chemical Peels

Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Original Effective Date: January 1994

Review Date: January 2026

Revised: January 2025

DISCLAIMER/INSTRUCTIONS FOR USE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations, or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

This Medical Policy document describes the status of medical technology at the time the document was developed. Since that time, new technology may have emerged, or new medical literature may have been published. This Medical Policy will be reviewed regularly and updated as scientific and medical literature becomes available; therefore, policies are subject to change without notice.

Related Policies:

- 10.01.02 Cosmetic and Reconstructive Services

Summary

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.

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 (QOL), 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. The evidence is insufficient to determine the effects of the technology on net health outcomes. However, even though there is a paucity in the peer-reviewed scientific literature based on clinical input and relevant professional society guidelines in which this treatment is supported, in select individuals with actinic keratoses dermal chemical peels will be considered medically necessary when the criteria below are met, see Policy below.

For individuals who have moderate- to- severe active acne who receive epidermal chemical peels, the evidence includes a split-face RCT and an active-comparator, split-face study. Relevant outcomes are symptoms, morbid events, QOL, and treatment-related morbidity. Results from the small randomized, placebo-controlled, split-faced trial found greater efficacy with active treatment than with placebo and the additional split-face study in mild-to-moderate acne found similar outcomes with once-daily dapsone gel and every 2-week chemical peels after 3 months. However, no randomized studies in moderate-to-severe acne were identified comparing chemical peel agents with conventional acne treatment. The evidence is insufficient to determine the effects of the technology on net health outcomes. However, even though there is a paucity in the peer-reviewed scientific literature based on clinical input and relevant professional society guidelines in which this treatment is supported, in select individuals with moderate- to- severe active acne epidermal chemical peels will be considered medically necessary when the criteria below are met, see Policy below.

Additional Information

Clinical input obtained in 2010 supported the use of chemical peels for treating multiple actinic keratoses.

Clinical input obtained in 2010 supported the use of chemical peels as second-line treatment of active moderate-to-severe acne.

OBJECTIVE

The objective of this evidence review is to evaluate the safety and efficacy of chemical peels dermabrasions for the treatment of actinic keratoses and moderate-to-severe acne.

PRIOR APPROVAL

Not applicable.

POLICY

Dermal chemical peels used to individuals 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 active acne in individuals who have failed to respond to a trial of topical and/or oral antibiotic acne therapy may be considered **medically necessary**.

Chemical peels for all other indications not meeting the above criteria are considered **not medically necessary** as the use of chemical peels has not been proven effective compared to other conventional methods of treatment for skin conditions.

POLICY GUIDELINES

Note: *Chemical peels, including treatment of photoaged skin, wrinkles, and acne scarring are considered cosmetic and non-covered, refer to medical policy* 10.01.02 Cosmetic and Reconstructive Services

Coding

See the Codes table for details.

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 patients. Potential local complications include scarring, infection, hypopigmentation, hyperpigmentation, activation of herpes simplex, and toxic shock syndrome.

Types of Peels

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, 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) 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 post inflammatory 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%. These lesions are generally considered to be a precursor of squamous cell carcinoma. The risk of progression to invasive squamous cell carcinoma is

unclear, but estimates vary from 0.1% to 20%. 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, surgical resection.

Acne vulgaris is the most common skin condition among adolescents, affecting an estimated 80% of teenagers aged 13 to 18 years old. 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.

Chemical peels also have several cosmetic uses including the treatment of photo-aged skin, uneven pigmentation, solar elastosis, and diminishing age-related wrinkles, *refer to medical policy* 10.01.02 Cosmetic and Reconstructive Services

Regulatory Status

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

RATIONALE

The evidence review was created in January 1994. It has been updated regularly with searches of the PubMed database. The most recent literature update was performed through January 2026.

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.

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. 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 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)
Alfaro et al (2012)	●
Di Nuzzo et al (2015)	●
Holzer et al (2017)	●
Kaminaka et al (2009)	●
Lawrence et al (1995)	●
Marrero et al (1998)	●
Sandoval Osses et al (2010)	●
Sumita et al (2018)	●

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

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Steeb et al (2020)	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 Systematic Reviews 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)				
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 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; were not identified; however, one active-comparator, split-face study in patients with mild-to-moderate acne has been published. Atallah et al (2025) published a single-center, split-face comparison of dapsone 7.5% gel once daily versus a TCA 20% chemical peel in 30 patients.[15,] The right side of the face was treated with a chemical peel every 2 weeks for 3 months and the left side was treated with the dapsone gel at night for 3 months. The percent change in Global Acne Grading Scale (GAGS) score was nonsignificantly higher on the dapsone-treated side than the peel side (50.5% vs 45.5%; p=.434). Lesion count was also similar between sides. Approximately 40% of people had good response (>75% regression in the number or size of comedones, papules, and pustules) with dapsone and 36.7% with the peel. The trial is limited by the single-center, small sample size, and limited duration design.

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. 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<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.

Section Summary: Moderate-to-Severe Active Acne

No RCTs comparing chemical peels to topical or oral medications in individuals with moderate-to-severe acne were found. One active-controlled, split-face trial was identified using a split-faced design with 30 patients who had mild-to-moderate acne. Outcomes (e.g., overall therapeutic effect) were similar with dapsone gel and a TCA chemical peel.One split-face RCT compared glycolic acid chemical peels to placebo and found greater improvement with the chemical peel. However, these trials enrolled a small number of individuals from a single center and provide 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 a guideline on the management of acne vulgaris, which makes the following statement regarding chemical peels:

“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. 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 Academy of 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. 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.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review can be located at clinicaltrials.gov.

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): 288-93. 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 meta-analysis. J Eur Acad Dermatol Venereol. Mar 2021; 35(3): 641-649. PMID 32745330
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
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): 615-25. 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): 176-81. 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. 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
19. UpToDate. Chemical Peels: Principles, peeling agents, and pretreatment assessment. Topic last updated December 2025. Also available at https://www.uptodate.com
20. UpToDate. Chemical Peels: Procedures and complications. Topic last updated March 2024. Also available at https://www.uptodate.com
21. UpToDate. Melasma: Management. Topic last updated September 2024. Also available at https://www.uptodate.com
22. UpToDate. Post-inflammatory hyperpigmentation. Topic last updated August 2025. Also available at https://www.uptodate.com
23. UpToDate. Light-based, adjunctive, and other therapies for acne vulgaris. Topic last updated June 2025. Also available at http://www.uptodate.com
24. UpToDate. Treatment of actinic keratosis. Topic last updated April 2025. Topic last updated July 2024. Also available at https://www.uptodate.com
25. UpToDate. Management of Acne Scars. Topic last updated December 2025. Also available at https://www.uptodate.com
26. Atallah DA, Bestawy SR, Abouelmajd SA, et al. Dapsone 7.5% Gel Versus Trichloroacetic Acid Peels. Dermatol Surg. Oct 03 2025. PMID 41042170

CODES

To report provider services, use appropriate CPT codes, HCPCS codes, Revenue codes, and/or ICD diagnosis codes.

Codes	Number	Description
CPT		
	15788	Chemical peel, facial; epidermal
	15789	Chemical peel, facial; dermal
	15792	Chemical peel, nonfacial; epidermal
	15793	Chemical peel, nonfacial; dermal
HCPCs		
	None	
Type of Service	Therapy	
Place of Service	Physician's office	

POLICY HISTORY

Date	Action	Action
January 2026	Annual Review	Policy Renewed
January 2025	Annual Review	Policy Revised
January 2024	Annual Review	Policy Renewed
January 2023	Annual Review	Policy Revised
January 2021	Annual Review	Policy Revised
March 2020	Annual Review	Policy Revised
June 2019	Interim Review	Policy Revised
March 2019	Annual Review	Policy Revised
March 2018	Annual Review	Policy Renewed
March 2017	Annual Review	Policy Revised
March 2016	Annual Review	Policy Revised
April 2015	Annual Review	Policy Renewed
May 2014	Annual Review	Policy Revised
July 2013	Annual Review	Policy Revised
November 2012	Annual Review	Policy Renewed
November 2011	Annual Review	Policy Renewed
November 2010	Annual Review	Policy Renewed

New information or technology that would be relevant for Wellmark to consider when this policy is next reviewed may be submitted to:

Wellmark Blue Cross and Blue Shield
Medical Policy Analyst
PO Box 9232
Des Moines, IA 50306-9232

*CPT® is a registered trademark of the American Medical Association.