



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

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Subject Rosacea Procedures

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Acne Procedures
Phototherapy and Photochemotherapy for Dermatological Conditions

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2008 CIGNA

Coverage Policy

Coverage for the treatment of rosacea is dependent on benefit plan language and may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit. Please refer to the applicable benefit plan language to determine benefit availability and the terms, conditions and limitations of coverage.

Please refer to the applicable pharmacy benefit to determine benefit availability and the terms and conditions of coverage for rosacea medications.

If coverage for treatment of rosacea is available, the following conditions of coverage apply.

CIGNA covers surgical excision and skin grafting/flap surgery for the treatment of advanced nodular rhinophyma as medically necessary when BOTH of the following criteria are met:

- The rhinophyma is documented to be causing a functional impairment (e.g., airway obstruction).
- Frontal, lateral, and worm's eye photographs document the functional impairment.

CIGNA does not cover treatment of the untoward cosmetic effects associated with rosacea (e.g., telangiectasia, erythema) because such treatment is considered cosmetic in nature and not medically necessary. Under many benefit plans, services are not covered when they are performed solely for the purpose of altering appearance or self-esteem, or to treat psychological symptomatology or

psychosocial complaints related to one's appearance. Rosacea treatments that are considered cosmetic in nature and not medically necessary include, but are not limited to:

- chemical peels of any type
 - dermabrasion
 - intense pulsed light (IPL)
 - laser therapy (e.g., pulsed dye)
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General Background

Any individual can develop rosacea, but it is more prominent in fair-skinned people of European and Celtic origin. It generally affects men and women between 25–60 years of age. Rosacea develops over a long period of time and often involves persistent redness, pimples and visible blood vessels in the center of the face that can eventually involve the cheeks, forehead, chin, nose, and eyes. Since rosacea may cause facial swelling and redness, it is easily confused with other skin conditions, such as acne and sunburn. The etiology of rosacea is unknown. Researchers have proposed that rosacea may be heredity or a result of environmental factors. One explanation is that something causes the blood vessels to swell which may cause the flushing and redness characteristic of rosacea. Another theory is that a mite called *Demodex folliculorum*, which lives in hair follicles, may clog oil glands, leading to the inflammation seen in rosacea. A bacterium called *Helicobacter pylori* (*H. pylori*), which causes intestinal infection, or the immune system might be other causes of the condition (Lee, et al., 2008; Habif, 2004); however, this has not yet been proven.

The diagnosis of rosacea is made clinically. A skin biopsy is sometimes performed to exclude diseases such as lupus or sarcoidosis. The most commonly used classification system is based on predominant lesion morphology and was developed by a committee of the National Rosacea Society. Patients are classified as having one of four types of rosacea: erythematotelangiectatic, papulopustular, phymatous, or ocular with a variant form referred to as granulomatous. Individual patients may overlap one or more subtypes, but this system allows physicians to determine therapy based on similar lesion types. Therapeutic options for the various lesion types are easily categorized, and there are few medications or modalities that are significantly effective in more than one category (Ferri, 2008; Baldwin, 2007).

The signs and symptoms of rosacea vary from person to person and are often intermittent. The clinical conditions of rosacea include (Hull, 2007; American Academy of Dermatology [AAD], 2007; Habif, 2004):

- Erythema or flushing of the face/neck: Rosacea can cause redness similar to that of a blush or sunburn. The flushing occurs when increased amounts of blood flow through vessels at a rapid rate, and the vessels expand to accommodate the blood flow. The redness may become more noticeable and persistent as the disease progresses.
- Pimples: The pimples, or papules and pustules, of rosacea, which often occur as the disease progresses, are different from those of acne because blackheads and whiteheads, known as comedones, rarely appear. The pimples, some containing pus, appear as small red bumps.
- Red lines: Some individuals with rosacea notice red lines, called telangiectasia, which appear when they flush. This is due to small blood vessels of the face becoming enlarged and showing through the skin. These red lines usually appear on the cheeks, especially when the overall redness diminishes.
- Bumps on the nose: Nasal bumps, a condition called rhinophyma, are an uncommon sign seen especially in untreated rosacea. Men are more likely to experience the small, knobby bumps on the nose, and as the number of bumps increases, the nose and cheeks may appear swollen.
- Facial dryness, burning, stinging or itching.

In addition to the skin manifestations of rosacea, about half of rosacea patients also have ocular rosacea, which can cause serious eye irritation. The most common complication of the eye associated with rosacea is an intermittent inflammatory conjunctivitis, with or without blepharitis. Prominent symptoms include eyes that are itchy, burning, or dry; a gritty or foreign body sensation; and erythema and swelling of the eyelid. The ocular changes can become chronic. Corneal neovascularization and keratitis can occur, leading to corneal scarring and perforation. Episcleritis and iritis have also been reported to occur in patients with rosacea (Blount, et al., 2002).

Treatments

Rosacea can be treated and controlled, but there is no cure. Since the pathophysiology of rosacea is unknown, the treatments or therapies of rosacea empirically target the signs and symptoms of the disease. When left untreated, rosacea often worsens and can become more difficult to treat. Treatment for rosacea is usually performed solely for cosmesis, with the primary purpose being to improve appearance of the skin. In rare cases, rosacea may be recalcitrant to standard medical therapy (i.e., advanced nodular rhinophyma) and surgical therapy may be indicated. In most patients who receive treatment, a stable state is reached with variable residual symptomatology. The classification system assists the physician in treatment by highlighting the presenting signs, therefore assisting in specifying which therapeutic approach to initiate.

There are four general stages of rosacea identified by signs and symptoms (Cohen, et al., 2002):

- Stage I: pre-rosacea involves frequent blushing
- Stage II: vascular stage involves transitory erythema of midfacial areas and early telangiectasias
- Stage III: deeper facial erythema involves increased telangiectasias and papule and pustule formation
- Stage IV: involves tissue hyperplasia with rhinophyma and possible ocular inflammation

Prior to initiating therapy, identification of any trigger factors should be considered. Triggers are both exposures and situations that can cause a flare-up of the flushing and skin changes in rosacea. Trigger factors are specific for each patient and do not affect every patient. Common triggers include: hot or cold temperature, wind, hot drinks, exercise, spicy food, alcohol, emotions, topical products that irritate the skin or impair barrier function, menopausal flushing, and medications that promote flushing. It is recommended that those trigger factors that induce flushing be avoided. Patients are recommended to use a broad-spectrum, gentle sunscreen daily; avoid midday sun, and use protective clothing when in the sun. The untoward cosmetic signs of rosacea may be camouflaged with nonirritating concealers and cosmetics. A combination of treatments is often prescribed, depending on the individual patient's needs. Sometimes both an oral antibiotic and a topical medication are prescribed (Kupiec-Banasikowska, et al., 2007; Pelle, et al., 2004).

Erythema or Flushing: Oral and topical therapies do not clear the redness or reduce the appearance of dilated blood vessels. Anti-inflammatory medication may be used to treat the erythema. Electrosurgery, intense pulse light (IPL) and laser surgery or vascular lasers are often used to destroy the visible blood vessels below the skin. Multiple IPL or laser therapy treatments may be needed to achieve the optimum results. Anecdotal evidence indicates treatment of rosacea with medications that reduce flushing may include anticholinergic medications (e.g., glycopyrrolate), beta-blockers, clonidine, and psychotropic medications. These medications can have serious side effects that must be weighed against potential benefits. These therapies or treatments do not treat the underlying cause of rosacea but rather the red appearance of the skin which is associated with rosacea; therefore, these treatments are cosmetic in nature.

Papules and Pustules: Topical medications (e.g., metronidazole) and/or oral antibiotics (e.g., doxycycline) are frequently prescribed. The oral antibiotics tend to work faster than the topical medications. Glycolic acid peels, washes, and creams have been proposed to be used in combination with oral antibiotics. Chemical peel solutions damage the outer layers of the skin and stimulate collagen formation, resulting in dermal regeneration, thereby improving the appearance of the skin. Alpha-hydroxy acids (AHA), such as glycolic, lactic, or fruit acid, are used in superficial peeling to rejuvenate and resurface sun-damaged skin, soften the appearance of pores, treat fine wrinkles and reduce uneven pigmentation. For severe cases, off-label use of the retinoid isotretinoin may be used to help shrink thickened facial skin and diminish nodular rosacea. Due to the serious side effects of isotretinoin, it is commonly reserved for cases in which multiple treatments have failed.

Ocular: It is recommended that those patients with eyelid inflammation cleanse their eyelids often by gently scrubbing the eyelids with diluted baby shampoo or an over-the-counter eyelid cleaning product and apply warm compresses several times daily. Oral antibiotics are used to treat the ocular symptoms of rosacea. A short course of topical corticosteroid solution may be useful for symptomatic relief of ocular rosacea. It is recommended that ocular steroid therapy be initiated and managed by an ophthalmologist because experience with this treatment is limited. Liquid tears are useful for dry eyes and relief of ocular itching. Low-dose treatment with oral isotretinoin has also been successful in recalcitrant ocular cases (Randleman, et al., 2007).

Rhinophyma: Early treatment of rhinophyma is recommended to help prevent the condition from progressing and becoming more difficult to treat. Changes due to rhinophyma can become permanent. Symptoms include overgrowth of the sebaceous skin glands, vessel and tissue growth in the deeper layers of the skin, and a thickening of the outer layer of the skin. This can make for a very obvious and prominent nose which can cause emotional distress by the change in appearance. The nasal skin can be erythematous with telangiectasias and sometimes become purple in color. In severe cases, the skin can have pits, fissures, and scarring. There can be infection and bleeding. In the rare advanced stages, rhinophyma can result in collapse of the nostrils, resulting in airway obstruction. Rhinophyma does not respond well to medical therapy. Rhinophyma can be corrected surgically, but the condition may recur. Generally, cosmetic surgery is performed to remove thickened tissue that can appear around the nose. The following cosmetic treatments are used to sculpt areas to a more normal appearance: dermabrasion, cryosurgery, electrosurgery, and/or laser surgery.

Surgical procedures are indicated for the treatment of advanced nodular rhinophyma, which may result in functional impairment such as airway obstruction. The surgical procedures can broadly be divided into full excision of the abnormal tissue and repair of the defect by graft or flap, and partial excision leaving the lower part of the pilosebaceous unit intact (superficial decortication). It has been reported that the latter appears to result in better results and is the treatment of choice. Treatment options may be combined to obtain best results. These procedures may be performed on an outpatient basis using local or general anesthesia, and healing generally takes 7–10 days or more for re-epithelialization (AAD, 2007; Gupta, et al., 2005; Laube, et al., 2002; Rohrich, et al., 2002).

Laser and Intense Pulsed Light (IPL) Treatment: Lasers have been used since the mid-1980s to treat rosacea. An ever-increasing number of lasers and a non-laser light therapy called intense pulsed light (IPL) are available for treating rosacea. Data on the effectiveness and safety of lasers and non-laser light therapy is limited. The U.S. Food and Drug Administration (FDA) classifies laser and light therapies as procedures; therefore, long-term studies are not required. Most of what is known comes from observations made while treating individual patients. The newest generation of vascular lasers does not produce any bruising but may cause redness and swelling that lasts approximately 24–48 hours. Both treatments, laser and IPL, take 15–30 minutes and are performed at 6–12 week intervals. Patients may require several treatments initially and return annually for treatment of new blood vessels. It is recommended that patients continue to consult their primary care physician or dermatologist for treatment and avoid personal rosacea triggers (AAD, 2007). These therapies or treatments do not treat the underlying cause of rosacea but rather the appearance of the skin; therefore, these treatments are cosmetic in nature.

The FDA has granted 510(k) approval for several light and laser systems which can be found on the FDA 510(k) database. IPL is referred to by a variety of trade names or service marks (e.g., FotoFacial™, PhotoDerm®, PhotoFacial™, EpiLight™, MultiLight™, and PlasmaLight™).

There are a variety of lasers including, but not limited to (Laube, et al., 2002):

- argon
- carbon dioxide (CO₂)
- copper-bromide
- erbium: yttrium aluminum garnet (Er:YAG)
- krypton
- neodymium: yttrium aluminum garnet (Nd:YAG)
- potassium-titanyl-phosphate (KTP)
- pulsed dye (e.g., Candela V-Beam)

A Hayes review of the literature on phototherapy for acne vulgaris included evaluations of PDT, pulse dye laser (PDL) therapy and visible light treatments. The report found that the overall body of evidence regarding the efficacy of phototherapy for the treatment of acne to be very limited due to the small number of studies and small sample sizes in available studies (Hayes, 2005).

A Hayes review of the literature on laser and light therapies for rosacea included any form of light or laser therapy for rosacea. Studies were excluded if individuals were treated for rhinophyma, ocular rosacea or non-rosacea telangiectasia. The report found that there is some promising but limited evidence from several

prospective studies that laser and light therapies may reduce the signs and symptoms of facial rosacea with relatively few side effects. The overall quality of evidence was weak, and the few available studies were small, differed in patient selection criteria and treatment protocols, lacked comparison of phototherapy with standard therapies, and most provided only short follow up. There is uncertainty regarding the optimal timing of therapy for best management of symptoms, as well as questions regarding how laser and light therapies fit into the overall continuum of rosacea treatment, and how these therapies apply to each of the four rosacea subtypes (Hayes, 2007).

Summary

The pathophysiology of rosacea is unknown and therefore it is a complex disease to treat. The treatments or therapies of rosacea empirically target the signs and symptoms of the disease. The visually apparent symptoms of rosacea (i.e., erythema, telangiectasias, pustules, papules, and rhinophyma) may be psychologically debilitating for some patients. Medical and surgical treatment is usually performed for cosmesis, with the primary purpose being to improve appearance of the skin. In rare instances, advanced nodular rhinophyma may result in a functional impairment (e.g., airway obstruction) and medically necessary surgical treatment may be indicated.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT ^{®*} Codes	Description
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15261	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm (List separately in addition to code for primary procedure)
15630	Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips
30120	Excision or surgical planing of skin of nose for rhinophyma

ICD-9-CM Diagnosis Codes	Description
695.3	Rosacea

Not Medically Necessary/Cosmetic/Not Covered for the treatment of the untoward cosmetic effects associated with rosacea:

CPT* Codes	Description
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Demabrasion; superficial, any site, (e.g., tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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

17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; 15 or more lesions
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***Current Procedural Terminology (CPT®) ©2007 American Medical Association: Chicago, IL.**

References

1. American Academy of Dermatology (AAD). Rosacea. Revised 2005. Accessed August 18, 2008. Available at URL address: <http://www.aad.org/>
2. American Academy of Dermatology (AAD). Rosaceanet. A comprehensive online rosacea information resource. Rosacea treatment. Updated July 17, 2008. Accessed August 18, 2008. Available at URL address: <http://www.skincarephysicians.com/rosaceanet/treatment.html>
3. American Academy of Dermatology (AAD). Rosaceanet. A comprehensive online rosacea information resource. Is laser treatment right for your rosacea? Updated March 6, 2007. Accessed August 18, 2008. Available at URL address: <http://www.skincarephysicians.com/rosaceanet/treatment.html>
4. Baldwin HE. Systemic therapy for rosacea. *Skin Therapy Lett.* 2007 Mar;12(2):1-5, 9.
5. Blount BW, Pelletier AL. Rosacea: a common, yet commonly overlooked, condition. *Am Fam Physician.* 2002 Aug 1;66(3):435-40.
6. Clark SM, Lanigan SW, Marks R. Laser treatment of erythema and telangiectasia associated with rosacea. *Lasers Med Sci.* 2002;17(1):26-33.
7. ClinicalTrials.gov. Acne Rosacea. Accessed August 18, 2008. Available at URL address: <http://clinicaltrials.gov/search/open/condition=%22Acne+Rosacea%22>
8. Cohen AF, Tiemstra JD. Diagnosis and treatment of rosacea. *J Am Board Fam Pract.* 2002 May-Jun;15(3):214-7.
9. Crawford GH, Pelle MT, James WD. Rosacea: I. Etiology, pathogenesis, and subtype classification. *J Am Acad Dermatol.* 2004 Sep;51(3):327-41; quiz 342-4.
10. Del Rosso JQ, Baldwin H, Webster G; American Acne & Rosacea Society. American Acne & Rosacea Society rosacea medical management guidelines. *J Drugs Dermatol.* 2008 Jun;7(6):531-3.
11. Feldman SR, Fleischer AB. Acne vulgaris and rosacea. In: Rakel RE, Bope ET, editors. *Rakel: Conn's current therapy 2008.* 60th ed. Philadelphia, PA: Saunders; Ch 194.
12. Ferri FF. Rosacea. *Ferri's clinical advisor 2008: instant diagnosis and treatment.* Philadelphia, PA: Mosby; 2008.
13. Gupta AK, Chaudhry MM. Rosacea and its management: an overview. *J Eur Acad Dermatol Venereol.* 2005 May;19(3):273-85.
14. Habif TP. Acne, rosacea, and related disorders. In: Habif TP, editor. *Clinical dermatology. A color guide to diagnosis and treatment.* 4th ed. Philadelphia, PA: Mosby; 2004. Ch 7.
15. Hayes Directory™. Laser and light therapies for rosacea. Lansdale, PA: HAYES, Inc.; ©2007 Winifred S. Hayes, Inc. October 23, 2007.
16. Hull SK. Acne vulgaris and acne rosacea. In: *Rakel: Integrative medicine.* 2nd ed. Philadelphia, PA: Saunders; 2007. Ch 73.

17. International Rosacea Foundation. Laser treatments. Accessed August 18, 2008. Available at URL address: <http://www.internationalrosaceafoundation.org/>
18. Kawana S, Ochiai H, Tachihara R. Objective evaluation of the effect of intense pulsed light on rosacea and solar lentigines by spectrophotometric analysis of skin color. *Dermatol Surg.* 2007 Apr;33(4):449-54.
19. Kupiec-Banasikowska A, Ogholikhan M, Ratnavel R. Rosacea. E-medicine from WebMD. Updated Feb 22, 2007. Accessed August 18, 2008. Available at URL address: <http://www.emedicine.com/>
20. Laube S, Lanigan SW. Laser treatment of rosacea. *J Cosmet Dermatol.* 2002 Dec;1(4):188-95.
21. Lee DJ, Shellow WV. Management of rosacea and other acneiform dermatoses. In: Goroll AH, Mulley AG, editors. *Primary care medicine.* 6th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2008. Ch 186.
22. Lonne-Rahm S, Nordlind K, Edstrom DW, Ros AM, Berg M. Laser treatment of rosacea: a pathoetiological study. *Arch Dermatol.* 2004 Nov;140(11):1345-9.
23. Mark KA, Sparacio RM, Voigt A, Marenus K, Sarnoff DS. Objective and quantitative improvement of rosacea-associated erythema after intense pulsed light treatment. *Dermatol Surg.* 2003 Jun;29(6):600-4.
24. Medline Plus. Rosacea. Updated June 26, 2008. Accessed August 18, 2008. Available at URL address: <http://www.nlm.nih.gov/medlineplus/rosacea.html#cat27>
25. Myers P, Bowler P, Hills S. A retrospective study of the efficacy of intense pulsed light for the treatment of dermatologic disorders presenting to a cosmetic skin clinic. *J Cosmet Dermatol.* 2005 Dec;4(4):262-6.
26. National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). What is Rosacea? March 2005. Accessed August 18, 2008. Available at URL address: <http://www.niams.nih.gov/>
27. National Rosacea Society. Accessed August 18, 2008. Available at URL address: <http://www.rosacea.org/about/index.php>
28. Orenstein A, Haik J, Tamir J, Winkler E, Frand J, Zilinsky I, Kaplan H. Treatment of rhinophyma with Er:YAG laser. *Lasers Surg Med.* 2001;29(3):230-5.
29. Parker F, Shaw JC. Acne vulgaris and acne rosacea. In: Noble J, editor. *Noble: textbook of primary care medicine.* 3rd ed. Philadelphia, PA: Mosby; 2001. Ch 84.
30. Pelle MT, Crawford GH, James WD. Rosacea: II. Therapy. *J Am Acad Dermatol.* 2004 Oct;51(4):499-512; quiz 513-4.
31. Randleman JB, Loft E, Song CD. Ocular Rosacea. E-medicine from WebMD. Updated May 14, 2007. Accessed August 18, 2008. Available at URL address: <http://www.emedicine.com/>
32. Rebora A. The management of rosacea. *Am J Clin Dermatol.* 2002;3(7):489-96.
33. Rohrich RJ, Griffin JR, Adams WP Jr. Rhinophyma: review and update. *Plast Reconstr Surg.* 2002 Sep 1;110(3):860-69.
34. Romagnolo SC, Benedetto AV. Rosacea in a new light. *Skinmed.* 2005 Jan-Feb;4(1):47-8.
35. Tan SR, Tope WD. Pulsed dye laser treatment of rosacea improves erythema, symptomatology, and quality of life. *J Am Acad Dermatol.* 2004 Oct;51(4):592-9.

36. U.S. Food and Drug Administration. Center for Devices and Radiological Health. 510(k) database. Updated August 6, 2008. Accessed August 18, 2008. Available at URL address: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/PMNSimpleSearch.cfm>
37. Van Zuuren EJ, Graber MA, Hollis S, Chaudhry M, Gupta AK, Gover M. Interventions for rosacea. Cochrane Database Syst Rev. 2005 Jul 20;(3):CD003262.
38. Van Zuuren EJ, Gupta AK, Gover MD, Graber M, Hollis S. Systematic review of rosacea treatments. J Am Acad Dermatol. 2007 Jan;56(1):107-15.
39. Wilkin J, Dahl M, Detmar M, Drake L, Liang MH, Odom R, Powell F; National Rosacea Society Expert Committee. Standard grading system for rosacea: report of the National Rosacea Society Expert Committee on the classification and staging of rosacea. J Am Acad Dermatol. 2004 Jun;50(6):907-12.

Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	10/15/2007	0482	Rosacea Procedures

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