	POLICIES AND PROCEDURES
Policy #: 404-1103	Lead Department: Utilization Management
Title: Hair Removal	
Original Date: 10/14/2022	Policy Hub Approval Date: 10/14/2022
Approved by: UMWG	

Purpose: The purpose of this policy is to describe conditions for which Alliance considers hair removal medically necessary and authorization limits for hair removal.

Policy:

The Alliance considers hair removal potentially medically necessary as part of gender-affirming treatments and for hirsutism associated with medical conditions and medication.

Definitions:


Gender dysphoria: Discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth.

Hirsutism: Excess terminal hair growth (dark coarse hairs) in androgen-dependent areas (upper lip, chin, mid-sternum, upper abdomen, back and buttocks) in which women typically have little or no hair.

World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, The World Professional Association for Transgender Health (WPATH): an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health.

Procedures:

1. Alliance Coverage
 - a. For members that meet WPATH criteria for gender transformation surgery, genital area hair removal in preparation for the procedure is covered, when determined medically necessary according to Alliance Policy 404-1112 – Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests, and meets the criteria listed below.
 - b. Eligibility for hair removal from the face & neck, back, abdomen and chest requests require that::
 - i. The Member has diagnosis of persistent gender dysphoria, or there is significant disruption of professional and/or social life because of hirsutism; and,
 - ii. A PCP, Dermatologist, or surgeon that performs gender affirmation procedures completes an evaluation of the Member for psychological distress related to the presence of unwanted hair and provides clearly documented justification of medical necessity.
 - c. Hair removal from the extremities, axilla and buttocks are not covered benefits.

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2. Referral Requests

- a. Prior Authorization is required for Hair Removal, and all requests will adhere to the process described in Alliance Policy 404-1201 – Authorization Request Process.
- a. Prior to initial referral, and every 6 months thereafter, an evaluation by a PCP, dermatologist or surgeon is required to justify hair removal services. The evaluation must include the following:
 - i. An evaluation of the Member for psychological distress related to the presence of unwanted hair and justification of medical necessity of hair removal;
 - ii. Body area(s) and photos of body area(s) that require treatment; and,
- b. Evaluations to determine medical necessity may not be completed by an Electrolysis Provider.

3. Procedure Requests and Limitations

- a. Laser Hair Removal Procedure Requests:
 - i. Diagnosis and documentation justifying hair removal services for specific body areas (face/neck, back, chest, abdomen, genitalia)
 - ii. Use CPT procedure code 17999 indicating daily treatment per body area (face/neck or back or chest or abdomen or genitalia (each representing 1 body area)
 - iii. Maximum 1 (one) CPT 17999 units per day per body area; 3 (three) units CPT 17999 in 3-month period per body area;
 - iv. Frequency of treatment visits is to be no more frequent than every 4 weeks;
- b. Electrolysis Hair Removal Requests
 - i. Diagnosis and documentation justifying hair removal services for specific body areas (face/neck, back, chest, abdomen, genitalia)
 - ii. Electrolysis hair removal is to use CPT procedure code 17380 indicating 30 minutes of treatment, all inclusive, regardless of body area being treated;
 - iii. Requests are to have a maximum 4 (four) CPT 17380 units per day; 48 (forty-eight) CPT 17380 units in 3 (three) months


References:

Alliance Policies:

- 404-1112 – Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests
- 404-1201 – Authorization Request Process

Impacted Departments:

- Member Services
- Provider Services
- Claims

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Regulatory:

Legislative:

Contractual (Previous Contract):

Contractual (2024 Contract):

DHCS All Plan Letter:

NCQA:

Supersedes:

Other References:

Apollo Managed Care, Medical Review Criteria Guidelines for Managing Care 20th edition, 2021. PRS 117B: Hair-Transplantation or Removal; Hirsutism.

Battle, E, Jr and LM Hobbs- 2004. Laser-assisted hair removal for darker skin types, Dermatologic Therapy 17: 177-183.

Centers for Medicare & Medicaid Services, 2016. National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9).

Coleman, E., Bockting, W., et. al. "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7." International Journal of Transgenderism, 13:165-232, Co. 2011: World Professional Association for Transgender Health.

California Department of Health Care Services, All Plan Letter 20-018 Ensuring Access to Transgender Services. Accessed October 26, 2021.

Hussain M, Polnikorn, N, DJ Goldberg. 2003. "Laser-assisted hair removal in Asian skin: efficacy, complications, and the effect of single versus multiple treatments", Dermatol Surg., 29(3):249.

Barbieri RL, Ehrman DA, 2019. Evaluation of premenopausal women with hirsutism.

Attachments:

Lines of Business This Policy Applies To

- Medi-Cal
- Alliance Care IHSS

LOB Effective Dates

- (01/01/1996 – present)
- (07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By