| KAISER PERMANENTE® Mid-Atlantic States | **Laser treatment/ Electrolysis for Hair Removal or Hair Reduction Medical Coverage Policy** |
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**Utilization *ALERT***

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements
- This MCP applies if no CMS criteria are available.

## I. Procedure: Hair Removal or Hair Reduction through Laser treatment or Electrolysis

## II. Specialty: Dermatology, Surgery

## III. Clinical Indications for Referral

Hair removal or hair reduction by a laser or electrolysis is considered medically necessary for the following conditions:

A. Transgender Genital Surgery – Sex reassignment pre "bottom" surgery (laser or electrolysis covered).
The hair removal of a defined area in the tissue donor site (s) for a planned surgical phalloplasty or planned surgical vaginoplasty must meet all of the following:
   1. An approved authorization for a planned transgender surgery;
   2. Proof of medical necessity for hair removal from the treating surgeon; and
   3. Defined area to be treated from the treating surgeon:
      *a.* Location and size of the area to be treated; *and*
      b. Expected date of planned genital surgery

B. Transgender Genital Surgery—post approved "bottom" surgery for neovaginal hair growth complications (laser or electrolysis covered). Please note, electrolysis is more likely to be utilized for this purpose.

C. Hair removal for the face and neck for transgender patients (by laser or electrolysis) must meet all of the following:
   1. Member has been diagnosed by a qualified licensed mental health professional with gender dysphoria/gender incongruence; and
   2. Member has lived as their affirmed gender full-time for 12 months or more; and
   3. Member has completed 6 continuous months of hormone therapy appropriate to their desired gender (unless medically contraindicated); and
   4. Hair removal for face and/or neck has been recommended by a board-certified dermatologist or licensed treating provider.

D. Skin grafting/surgical laser hair removal at site of skin graft;

E. Hair follicle disorders that have failed more conservative measures, including but not limited to:
   1. Acne Keloidalis Nuchae;
   2. Pseudofolliculitis Barbae;
   3. Hidradenitis Suppurativa;
   4. Folliculitis Decalvans; and
   5. Dissecting Cellulitis of the Scalp
*F.* Becker's Nevi; *and*
G. Residual-Limb-prosthetic interface

**IV. Limitations/Exclusions**

Laser treatment is considered not medically necessary for the following:
A. For cosmetic purposes such as to improve or change appearance;
B. To alter gender-specific appearance for an individual with gender dysphoria; not associated with an approved surgical procedure or medically necessary facial hair removal;
C. Cosmetic surgery of benign asymptomatic cutaneous lesions;
D. Rosacea and Rhinophyma; *and*
E. Acne Vulgaris

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## Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

| Date approved by RUMC | Date of Implementation |
|---|---|
| 09/26/2018 | 09/26/2018 |
| 09/26/2019 | 09/26/2019 |
| 09/24/2020 | 09/24/2020 |
| 09/27/2021 | 09/27/2021 |
| 07/26/2022 | 07/26/2022 |
| 07/25/2023 | 07/25/2023 |
| 07/24/2024 | 07/24/2024 |

*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.