SFHP: Facial Hair Removal Provider Guide

Newly Available Coverage:
As of February 20, 2015 San Francisco Health Plan amended their guidelines to include *limited* coverage for facial hair removal for transgender patients who meet medical necessity.

Expanded coverage for medically necessary gender-related procedures has often been gained through winning coverage for individual patient cases. This is typically a lengthy process that requires a series of denials and strong provider advocacy documenting medical necessity.

This guide provides an overview of how to make a referral for facial hair removal, how to fill out Prior Authorization forms, what clinical documents to attach to them, and how to appeal a denial.

Note: Facial Hair Removal is not currently covered by Medicare, Medi-Cal Fee-For-Service, Anthem Blue Cross Medi-Cal, or HSF

Documenting Medical Necessity:
First, in order to get approved for coverage a patient must meet medical necessity for treatment. Medical necessity can be documented in the form of a letter from the mental health provider describing how facial hair contributes to gender dysphoria or discomfort/anxiety stepping out into the world visibly, and any other ways in which hair on the face is harmful to a patient, such as increased risk for violence. The PCP may also supplement the referral with a medical history and physical, although that is not explicitly required in the guidelines.

Hair Removal Options:
You may already know the difference between laser and electrolysis, but to summarize: laser is not effective on darker skin, light hair, red hair, or gray/white hair. Laser is also contraindicated if patients have used antibiotics 3 days before or 3 days after treatment, have used blood thinners 1 week before or 1 week after treatment or have a history of melanoma. However, laser covers more area more quickly, and is considered by some patients to be less painful than electrolysis, which pricks each and every hair follicle with an electrified needle to kill the hairs. That is why laser is preferred by many patients for the face and other body parts, even though it is less effective, requiring touch-ups over time, and even though it is not suitable for patients with the above conditions and skin/hair pigmentations.

If your patient chooses electrolysis:
San Francisco Health Plan has set up a contract for electrolysis with Dimitra's Skin Care in West Portal. For patients requiring facial electrolysis, this will be the most straightforward electrolysis provider to refer them to. If approved, the patient would have a co-pay of $0.

Hair Removal Continued:

If your patient chooses laser:

For patients requiring laser hair removal, the provider options are a little more complex. Technically, a patient can choose any laser provider who would be willing to accept SFHP's reimbursement rate and set up a mechanism for billing. However, it may be challenging for businesses that are used to patients paying out of pocket to set up insurance billing. UCSF Dermatologic Surgery and Laser Center is a local laser hair removal provider.

If the patient is approved for laser hair removal, the next step would be for the SFHP contracts office to work with the designated provider to set up a letter of agreement. Realistically, this contracting process could take a few months and you may want to alert your patient to the reality of a long waiting period while the contract gets sorted out. Over time, once more patients have gone through the approvals process and a laser business has been established, the process should be a lot smoother.

To Submit a Prior Authorization for Facial Hair Removal:

1) Obtain any available clinical documentation for medical necessity including assessment from MH providers.
    a. If patient opts for electrolysis, PCP must document:
        i. a medically necessary referral in a progress note, dated no more than 3 months from referral date.
    b. If patient opts for laser, PCP letter must document:
        i. that there are no contraindications for treatment (see list above)
        ii. a medically necessary referral in a progress note, dated no more than 3 months from referral date.
2) Complete Prior Authorization Form (see template Prior Auths attached)
    a. Use 302.85 (Gender Dysphoria) as diagnostic code.
    b. Indicate patient's preference for laser or electrolysis.
        i. If patient selects electrolysis, service code is: 17380, indicate 40 in "quantity" field
        ii. If patient selects laser, service code is: 17999, indicate 6 in "quantity" field
3) Fax Prior Authorization with clinical information to SFHP
    a. NOTE: Instances that end up requiring treatment for greater than 3 months for electrolysis or 6 months for laser hair removal necessitate the submission of modification requests that include documentation from the servicing provider stating a need for continuing services

Possible outcomes of Prior Authorization Submission:

1) Approval 2) Deferral 3) Denial

If coverage is approved:

1) Provider will receive Notice of Action letter stating that procedure has been approved.
2) Usually patient does not receive approval and PCP will need to notify patient.
3) If electrolysis with Dimitra's was selected as the provider, patient can contact Dimitra's directly and inform them of the approval, phone: 415-731-8080
4) If laser was selected PCP will need to send referral to UCSF. PCP will need to fax a UCSF Referral Form with patient demographics, authorization from SFHP for services, current progress note and assessment written by licensed mental health provider to fax: 415-353-9503. Patient can contact practice directly, phone: 415-353-7878.

Hair Removal Continued:

If coverage is *deferred*:

1) A *Notice of Action Letter* is issued by SFHP describing that the decision for coverage of the procedure has been deferred. The letter will describe additional documentation required by SFHP before a coverage determination will be made.
2) PCP will need to submit the additional clinical information indicated on Notice of Action Letter directly to SFHP. Include patient's name, DOB, and write "Additional Clinical" on all materials submitted.
3) If there are questions about the documentation required, call SFHP Utilization Management department at: 415-547-7818 ext 7080.
4) SFHP will issue another Notice of Action Letter with coverage determination.

If coverage is *denied*:

1) A *Notice of Action Letter* is issued by SFHP stating that the procedure requested has been denied.
2) Obtain any additional clinical documents from PCP or MH provider to substantiate the medically necessity of hair removal.
3) Submit additional clinical information when applicable with a Provider Appeal and a Grievance to SFHP (template appeal and grievance forms available on SFHP website)
4) Concurrently file a request for an Independent Medical Review of the case and include all supporting clinical documents, including denial letter from SFHP. Request can be filed online or faxed: https://wpso.dmhc.ca.gov/complaint/

Prescribing Numbing Cream:
Hair removal is somewhat painful for most patients. Please offer each patient a prescription of the numbing cream named EMLA and advise patient to ask the hair removal provider for instructions on how to use it. Patients should bring the cream to their hair removal appointments. It is covered under the SFHP formulary.

One last note:
Gender Health SF does not have capacity to coordinate facial hair removal authorization requests at this time. If questions arise for patients or providers navigating coverage, providers and patients are advised to contact the SFHP Utilization Management Department at (415) 547-7818 ext 7080.

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FACIAL HAIR REDUCTION: ASSESSMENT EXPECTATIONS

Currently, SFHP reviews facial hair removal requests for medical necessity. We expect providers to submit authorizations with an assessment by a licensed behavioral health provider. We review these separately from gender affirmation surgery and require a separate assessment. Some members may not be at a place in their lives where they are stable enough for surgery but experience persistent gender dysphoria directly related to the presence of facial hair. This can be an important intervention and a step forward in addressing their gender dysphoria.

Specifics that should be addressed in the assessment:

1. How long has the member lived as their identified gender, (the expectation is a year)
2. ~~How long on hormones? (The expectation is a year)~~
3. How is the member functioning in the absence of service, (Impairment of function/ADLs)
4. How does impairment manifest? **Concrete examples**
5. Anticipated benefit (how would the service change the members level of functioning in society, how would it improve the quality of life)
6. Current method of hair removal
7. Does the member have ability to give informed consent and an understanding of the requested service?
8. Does the member have the ability and coping skills to sit still for up to two hours while tolerating discomfort, and with someone working in close proximity to their face?
9. Is member participatory in their care and regularly make appointments?

There are two options for hair reduction Electrolysis and laser

- Both options can be uncomfortable, but everyone's experience of pain is different
- Members will not see immediate results: hair reduction is a long process

For more specifics about electrolysis or laser hair reduction members should speak with a professional electrologist or laser technician.

San Francisco Department of Public Health
Gender Health SF
955 Potrero Avenue
Building 80, 8000N
San Francisco, CA 94110
Telephone: (628) 206-7979
genderhealthsf@sfdph.org
www.sfdph.org/genderhealthsf

Gender Assessment Form for Facial Hair Reduction

Please note:

1. **Facial Hair Reduction is *not* a pre-requisite for Facial Feminization Surgery.**
2. **For patients actively seeking Facial Feminization Surgery, they should consult with their surgeon regarding facial hair reduction.**

Client's name: Click here to enter text.
Legal name if different: Click here to enter text.
DOB: Click here to enter text.

Clinician name: Click here to enter text.
Office location or clinic: Click here to enter text.
Are you licensed? ☐ Yes ☐ No

Please describe your experience completing assessments for gender related surgeries. Click here to enter text.

How long have you known this client? Click here to enter text.

Please list the dates that you assessed this client for readiness and appropriateness for surgical intervention. If two people are signing the same letter, please list the dates you each assessed the client. Click here to enter text.

General and Gender Health

1. **Please describe this client (identifying characteristics, age, ethnicity, language, gender identity, housing situation, etc.).** Click here to enter text.

2. **Please describe your client's experience of gender, their history of gender dysphoria and how they have attempted to address their gender dysphoria.** Click here to enter text.

3. **Please indicate the length of time your client has taken hormones. How do they describe their response to hormones (decreased dysphoria, could not tolerate them, etc.)? If they have not taken hormones or no longer take them, please explain.** Click here to enter text.

4. **Describe the client's capacity to give informed consent for facial hair reduction. If they lack capacity, please explain.** Click here to enter text.

5. **In attempt to provide the most effective education and preparation, please let us know about any issues we may need to know regarding communication. These could include English fluency, hearing impairments, autism spectrum, literacy level, learning differences, etc.** Click here to enter text.

6. **For each facial hair reduction, please describe how the procedure will improve your client's functioning. How will it improve their quality of life and health and decrease symptoms? Please include the client's words.** Click here to enter text.

<u>Psychiatric and Behavioral Health</u>

7. **Please give a brief description of your client's behavioral health history, including suicidality, homicidality, history of violence towards healthcare workers, any psychiatric hospitalizations and residential treatment for mental health or substance use.** Click here to enter text.

8. **Please list all current and past behavioral health diagnoses.** Click here to enter text.

9. **Please list all medications that the client is currently taking related to psychological concerns, sleep, or emotional problems, including herbal supplements like St. John's Wort and medical marijuana. These can affect anesthesia, bleeding and pain control. *Please include the prescriber next to the medication(s).*** Click here to enter text.

For facial hair reduction, it is important for patients and their care team to understand the differences between laser and electrolysis and that treatment will occur over a span of several months with numerous sessions.

Please review these topics to the best of your ability to ensure that your patient will be able to successfully complete treatment.

Reviewed	GHSF F/U?	
☐	☐	**10.** Laser vs. Electrolysis: Considerations of skin tone, hair color and hair type. Risks and benefits of the selected procedure and alternatives to the procedure
☐	☐	**11.** Pain: Possible difficulties with pain and pain management options.

☐ ☐ **12.** Realistic expectations about what the procedure can and cannot do physically, emotionally, and spiritually.

13. Is there anything you would like to add? Click here to enter text.

By signing this Assessment, I acknowledge that I am available for consultation and care coordination, as requested by Gender Health SF, the San Francisco Health Plan and Healthy SF.

Name, title and license: Click here to enter text.

Signature:

_____

Date:

_____

Phone number for follow up: Click here to enter text.
E-mail number for follow up: Click here to enter text.

Name, title and license: Click here to enter text.

Signature:

_____

Date:

_____

Phone number for follow up: Click here to enter text.
E-mail number for follow up: Click here to enter text.

Please sign, print and fax this to your client's Primary Care Provider (*Not Gender Health SF*) so the PCP can review and submit a complete referral to San Francisco Health Plan.

Pre-Authorization Request Form

Fax: **(415) 357-1292**

Telephone: **(415) 547-7818 ext.7080**

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NOTE: All fields marked with an asterisk (*) are required.

Select all that apply: ■ New Request ☐ Modification Request for Authorization #: ☐ Second Opinion

Select type of request*: ☐ Urgent ■ Routine ☐ Retro (Must be submitted within 30 calendar days of date of service)

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service.

Please verify eligibility using one of the following methods:

1. Web: **www.sfhp.org/providers**
2. Interactive Voice Response: **(415) 547-7810**
3. SFHP Customer Services: **(800) 288-5555**

Select line of business: ■ Medi-Cal ☐ Healthy Kids ☐ Healthy Workers

Does additional coverage exist?* ☐ Yes ■ No If yes, specify the following: Carrier Policy#

PATIENT	REQUESTING PROVIDER
Name*:	■ Primary Care Provider ☐ Specialist ☐ Vendor/Ancillary
SFHP ID#: Date of Birth*:	Name*:
Gender: ☐ Male ☐ Female ☐ Other:	Telephone*:
Telephone:	**Contact Name:** Fax:
Address:	Address:
City: State: CA Zip:	City: State: CA Zip:

RENDERING PROVIDER

Name / Facility / Vendor*: UCSF Dermatologic Surgery and Laser Center ■ Out of Member's Medical Group ☐ Non-Contracted

Specialty*: Laser hair removal NPI#:

Telephone*: (415) 353-7878

Contact Name: Fax*: (415) 353-9503

Address: 1701 Divisadero, Suite 254

City: San Francisco State: CA Zip: 94115

Reason for out of medical group/non-contracted provider:

not available in group. *SFHP Please fax to rendering provider and PCP

DIAGNOSES / SERVICE CODES

At least one valid diagnosis code ***and*** one valid service code are required.*

Diagnosis Codes Please document diagnosis completely.

F64.9		

Service Codes Indicate quantity and modifiers (if applicable) for each code. If no quantity is indicated, the amount will default to 1. Ensure quantities are consistent with valid CPT/HCPCS values.

Code	Mod	Qty	Description	Code	Mod	Qty	Description
17999		6	laser hair removal				
99205		1	office/outpatient visit new				

Select hospital status*: ☐ Inpatient, number of days: ☐ Outpatient **Date of Service:**

Comments: Today's Date:

Important: Please attach appropriate clinical documentation to support your request.

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SFHP ID#: Date of Birth*:	Name*:
Gender: ☐ Male ☐ Female ☐ Other:	Telephone*:
Telephone:	**Contact Name:** Fax:
Address:	Address:
City: State: CA Zip:	City: State: CA Zip:

RENDERING PROVIDER

Name / Facility / Vendor*: UCSF Dermatologic Surgery and Laser Center ☒ Out of Member's Medical Group ☐ Non-Contracted

Specialty*: Laser hair removal NPI#:	Reason for out of medical group/non-contracted provider:
Telephone*: (415) 353-7878	not available in group. *SFHP Please fax to rendering provider and PCP
Contact Name: Fax*: (415) 353-9503	
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City: San Francisco State: CA Zip: 94115	

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Select hospital status*: ☐ Inpatient, number of days: ☐ Outpatient **Date of Service:**

Comments: Today's Date:

Important: Please attach appropriate clinical documentation to support your request.

UCSF Medical Center | UCSF Benioff Children's Hospital

REFERRAL FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form to the UCSF service to which you are referring your patient.

- Fax numbers can be found online at www.ucsfhealth.org/prd2010
- Include brief pertinent medical records, including test results that support the consultation

If you require additional assistance, please call (800) 444-2559 and ask for either the UCSF practice or the Referral Liaison Service.

Date:	From:
No. of pages:	Title:
To UCSF practice: Dermatologic Laser Center	Phone:
Fax: 415-353-9503	Fax:

PATIENT INFORMATION

Name of patient:

DOB: Interpreter needed: ❑ Yes ■ No Language:

Home phone: ❑ Work or ❑ cell phone:

If child, name of parent:

Address:

City: Zip:

Insurance: **Include patient's insurance card (both sides) and HMO authorization if required**

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD10 F64.1

Name of UCSF MD (if known): Specialty: Dermatologic Laser Center

Reason for consultation: Gender Dysphoria / LASER HAIR REDUCTION

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD:	Specialty:
Phone:	Fax:
PCP name:	Phone:

Signature: