BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Gender Affirmation Services

Policy Number: OCA 3.11
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Product Applicability	☒ **All Plan[+] Products**
WellSense Health Plan ☒ NH Medicaid ☒ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth ACO ☒ MassHealth MCO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

[+] Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Gender affirmation surgeries and permanent hair removal are considered **medically necessary** as treatment options for a member seeking treatment for gender dysphoria when the Plan's medical criteria are met. Gender affirmation surgeries may include one (1) or more surgical procedures and are part of a complex treatment plan involving medical, surgical, and behavioral health interventions to achieve the desired outcomes for the individual. When gender affirmation surgeries and/or permanent hair removal are requested for a member, **Plan prior authorization is required** and applicable Plan criteria must be met for each type of surgical procedure or service. It will be determined during the Plan's prior authorization process if the requested treatment is considered medically necessary.

Voice therapy is considered **medically necessary** as a treatment option for gender dysphoria. **Plan notification is required** for voice therapy according to the guidelines outlined in the Clinical Criteria section and Applicable Coding section. The Plan and the Plan's delegated clinical vendors conducting

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.

utilization management do NOT discriminate, arbitrarily deny, and/or impose stricter requirements by reducing the amount, duration, and/or scope of required and medically necessary services for ANY Plan member based on the member's diagnosis, type of illness, health status or condition, sex, gender identity/gender dysphoria, and/or sexual orientation.

Clinical Criteria

Individuals diagnosed with gender dysphoria may need to access a variety of medical and/or surgical treatments based on their individual needs, including a range of procedures to change primary and/or secondary sex characteristics. The full range of medical and/or surgical treatment options available to individuals diagnosed with gender dysphoria may include, but are not limited to, those listed in professional medical publications such as Standards of Care, Version 7, World Professional Association for Transgender Health (WPATH), 2012. See Item I for Plan notification guidelines for voice therapy and item II for medical necessity criteria and prior authorization requirements for gender affirmation surgery and permanent hair removal.

I. Voice therapy/voice training is considered medically necessary for the treatment of gender dysphoria when provided by a certified and licensed speech-language pathologist/speech therapist. **Plan notification** is required when voice therapy is billed with a waived principle (primary) ICD-10 diagnosis code for gender dysphoria and a speech therapy procedure code included the Applicable Coding section of this policy. The prior authorization waivers for speech therapy apply according to the guidelines in the *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting* medical policy applicable for the member (policy number OCA 3.551 for BMC HealthNet Plan members and OCA 3.542 for WellSense Health Plan members); OR

II. The Plan considers gender affirmation services medically necessary for the treatment of gender dysphoria, and **Plan prior authorization** is required for the services specified in this section. ALL applicable Plan clinical review criteria must be met in items A through D:

A. **Referral/Initial Assessment by Qualified Licensed Mental Health Professional:**

There is a referral/initial assessment from a **licensed qualified mental health professional** that contains ALL of the written documentation listed in items 1 through 8 related to the member's condition in the form of a letter:

1. An assessment of the member's gender identity and gender dysphoria resulting in a definitive diagnosis of persistent, well-documented **gender dysphoria (meeting DSM-5 criteria) for at least 6 months**, history and development of gender dysphoric feelings, and the impact of stigma attached to gender nonconformity on mental health; AND

Note: Plan Medical Director review is required when the member does NOT meet DSM-5 criteria for gender dysphoria (e.g., non-binary members who do not meet traditional diagnostic criteria for gender dysphoria).

2. The member's general identifying characteristics (including date of birth); AND

3. Results of the member's psychosocial assessment, including any diagnoses and confirmation that other behavioral health conditions are appropriately managed, reasonably controlled, and not causing symptoms of gender dysphoria; AND

4. The duration of the mental health professional's relationship with the member, including the type of evaluation and therapy or counseling to date; AND

5. A written clinical rationale supporting the member's request for the specific treatment(s) for gender dysphoria (i.e., hair removal and/or gender affirmation surgery); AND

6. A statement that the mental health professional is available for coordination of care and that a plan for coordination of care is in place; AND

7. The member's availability of support from family, friends, and/or peers (such as in-person or online contact with other transgender or gender nonconforming individuals or groups), as reported by the qualified licensed mental health professional treating the member; AND

8. The member's psychological readiness for the requested treatment(s) with no contraindications to treatment documented, including member's capacity to make a fully informed decision and has the capacity to consent for treatment(s), and includes parental or guardian consent (as applicable) if the member is younger than age 18 on the date of service unless the adolescent member is emancipated at the time the service is rendered; AND

B. **Member Age:**

The member is **age 18 or older*** on the date of service; AND

* Note: Plan Medical Director review is required for ANY gender affirmation surgery requested for a member **less than age 18** on the date of service. Requests for surgical treatment will be reviewed based on the Plan's *Medically Necessary* medical policy, policy number OCA 3.14, and the current version of the WPATH Standards of Care for Health and Transsexual, Transgender, and Gender-Nonconforming People. In addition, the Plan Medical Director will review the member's clinical situation, including but not limited to the amount of time the adolescent member has been living in the desired gender role, treatment timeframe with hormone therapy, age of the member, and the requested intervention. Adolescent members

may be eligible for interventions when adolescents and their parents (or guardian) make informed decisions about treatment, and the service is a covered benefit for the Plan member. Informed consent by a parent or guardian for treatment of an adolescent member may not apply if the adolescent member is emancipated at the time the service is rendered (as determined by state requirements).

C. **Service-Specific Criteria:**

Criteria must be met for each of the requested treatments for gender dysphoria, as specified below in item 1 for gender affirmation surgical procedures and item 2 for permanent hair removal:

1. **Gender Affirmation Surgical Procedures**:

Requests for prior authorization for each gender affirmation surgery must be submitted to the Plan by the surgeon (or the surgeon's designee) performing the procedure and accompanied by written clinical documentation that demonstrates the following criteria are met, as specified below in items a through j:

a. The treating surgeon is board certified or board eligible and appropriately qualified to perform the requested procedure (e.g., plastic surgery, otolaryngology, oral and maxillofacial surgery, or general surgery); AND

b. The treating surgeon has obtained or will obtain a written surgical consent from the member before performing the requested surgical procedure(s) and will document the written consent in the member's medical record; this includes obtaining parental or guardian written surgical consent before the requested surgical procedure(s), as applicable, if the member is younger than age 18 on the date of service (unless the adolescent member is emancipated at the time the service is rendered); AND

c. The treating surgeon has reviewed the written initial assessment by the qualified licensed mental health professional (referenced above in item A), confirmed that this mental health assessment verifies the DSM-5 diagnosis of gender dysphoria, and the surgeon is in agreement with the member's diagnosis. The surgeon will communicate with the qualified licensed mental health professional and any other health care professionals involved in the member's care, if necessary; AND

d. If any significant coexisting mental health concerns or medical conditions are identified prior to a gender affirmation surgery, medical record documentation shows that these conditions are being appropriately managed, reasonably controlled, and not causing symptoms of gender dysphoria; AND

e. If living in an identity-congruent gender role is a required criterion for a gender affirmation surgery (as specified in the procedure-specific criteria listed below), documentation of the member's experience in the gender role, including the start date of living full-time in the gender role; AND

f. If hormone therapy is a required criterion for a gender affirmation surgery (as specified below in the procedure-specific criteria), medical records must document member compliance with the prescribed regimen and clinical response over the course of hormone therapy; AND

g. The treating surgeon has personally communicated with the member and the member understands all of the different surgical techniques available and the advantages and disadvantages of each technique, the limitations of each technique to produce desired results, and the inherent risks and complications of the various techniques, including the surgeon's own complication rate with respect to each technique; AND

h. If the surgery is likely to result in sterilization, at least ONE (1) of the following criteria is met, as specified below in item (1) or (2):

   (1) The treating surgeon has discussed procedures for the preservation of fertility with the member prior to the surgery; AND/OR

   (2) The member reports to the treating surgeon that procedures for the preservation of fertility have been previously reviewed to the member's satisfaction with the treating independent licensed practitioner who initiated and provided the medical management of the member's hormonal therapy; AND

i. The member's treating surgeon has documented that there are no contraindications to the planned surgery and agree with the plan of care. Plan prior authorization must be obtained within the following applicable timeframe, as specified below in item (1) or item (2):

   (1) **Gender Affirmation Procedures NOT Requiring Medically Necessary Permanent Hair Removal of Graft Site**:

   The Plan will authorize medically necessary requests for gender affirmation surgery(ies) up to **12 calendar months** from the date of the authorization request;** OR

(2) **Genital Gender Affirmation Procedures Requiring Medically Necessary Permanent Hair Removal of Graft Site**:

The Plan will authorize medically necessary requests for genital gender affirmation procedure(s) that require pre-operative permanent hair removal as standard preparation for surgery up to **18 calendar months** from the date of the authorization request.

Review section C2 below for Plan guidelines on medically necessary permanent hair removal in preparation for genital gender affirmation surgery. Plan prior authorization for hair removal may be obtained either BEFORE requesting authorization for the genital gender affirmation surgery or at the same time the surgical procedure is authorized; AND

** Note: Plan Medical Director review is required when the documentation from the member's surgeon and/or qualified licensed health provider(s) (i.e., verification that there are no contraindications to the planned procedure and agree with the member's plan of care) is within 13-18 calendar months of the prior authorization request and permanent hair removal is NOT a medically necessary component of pre-operative preparation for genital gender affirmation procedure(s). Additional documentation must be submitted to the Plan to report the extenuating circumstances that necessitate an extension of the standard 12 calendar month time limit.

j. Procedure-Specific Criteria:

Procedure-specific criteria must be met for ANY of the procedures listed in items (1) through (4):

(1) Chest Procedures:

(a) **Bilateral augmentation mammoplasty** (with implantation of breast prostheses or lipofilling) is considered medically necessary when BOTH of the following criteria are met, as specified below in item i and item ii:

i. Member has persistent, well-documented gender dysphoria and criteria are met for items A B, and C (for requested service); AND

ii. The member has had 12 continuous months of clinician-supervised hormone therapy (unless hormone therapy is medically contraindicated for the member), and the hormone therapy has not resulted in

sufficient breast development as self-reported by the member to the treating provider; OR

(b) **Bilateral breast reduction, mastectomy, and/or chest reconstruction** are considered medically necessary for a member with persistent, well-documented gender dysphoria when criteria are met in items A through C (for the requested service); OR

(2) Feminizing Genital Surgery: ∞

Feminizing genital surgical procedures are considered medically necessary when the member has persistent, well-documented gender dysphoria, criteria are met for items A through C (for the requested service), and ALL guidelines are met in items (a) through (d):

(a) ANY of the procedures in items i through vi will be performed:

i. Clitoroplasty/neoclitoroplasty;

ii. Labiaplasty/neolabiaplasty;

iii. Orchiectomy;

iv. Penectomy;

v. Vaginoplasty (also known as neovaginoplasty); e.g., colovaginoplasty, peritoneal pulldown vaginoplasty; ∞

∞ Note: See the medical necessity guidelines for hair removal (using electrolysis and/or laser ablation treatments) on a skin graft to be used in genital affirmation procedure (e.g., hair removal for vaginoplasty).

vi. Vulvoplasty/neovulvoplasty; AND

(b) The member has been assessed by two (2) independently licensed health professionals, one of whom must be a licensed qualified behavioral health professional (referenced above in item A) and the other a clinician familiar with the member's health, with each assessment resulting in a diagnosis of gender dysphoria meeting DSM-5 criteria. The initial diagnosis (from one professional) must have been present for at least 6 months; AND

(c) The member has had 12 continuous months of living as the gender that is congruent with the member's identity. Exceptions may be provided on a

case-by-case basis should the request for prior authorization document that compliance with this requirement would jeopardize the health, safety, and/or well-being of the member; AND

(d) The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated; OR

(3) Masculinizing Genital Surgery: ∞

Masculinizing genital surgery is considered medically necessary for the treatment of persistent, well-documented gender dysphoria when criteria are met for items A through C (for the requested service) and ALL guidelines are met in items (a) through (d):

(a) ANY of the procedures in items i through ix will be performed:

i. Hysterectomy;

ii. Metoidioplasty (micropenis);

iii. Oophorectomy;

iv. Phalloplasty with implantation of penile prosthesis; ∞

∞ Note: See the medical necessity guidelines for hair removal (using electrolysis and/or laser ablation treatments) on a skin graft to be used in a genital affirmation procedure (e.g., hair removal for phalloplasty).

v. Salpingectomy;

vi. Scrotoplasty with insertion of testicular implants;

vii. Urethroplasty;

viii. Vaginectomy;

ix. Vulvectomy; AND

(b) The member has been assessed by 2 independently licensed health professionals, one of whom must be a licensed qualified behavioral health professional (referenced above in item A) and the other a clinician familiar with the member's health, with each assessment resulting in a diagnosis of

gender dysphoria meeting DSM-5 criteria. The initial diagnosis (from 1 professional) must have been present for at least 6 months; AND

(c) The member has had 12 continuous months of living as the gender that is congruent with the member's identity. Exceptions may be provided on a case-by-case basis should the request for PA document that compliance with this requirement would jeopardize the health, safety, or well-being of the member; AND

(d) The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated; OR

(4) Facial Feminization or Facial Masculinization Gender Affirmation Surgical Procedures:

Facial feminizing or facial masculinizing gender affirmation procedures are considered medically necessary for the treatment of persistent, well-documented gender dysphoria when ALL criteria are met in items (a) through (c):

(a) Criteria are met for items A, B, and C (for requested procedure); AND

(b) ANY of the following facial feminizing surgeries or facial masculinizing procedures in items i through xv will be performed:

i. Blepharoplasty (eyelid surgery) ONLY in conjunction with other medically necessary facial feminization or facial masculinization procedures;

Note: See the Limitations and Exclusions section for Plan clinical guidelines for blepharoplasty when NOT performed in conjunction with other medically necessary facial procedures for the treatment of gender dysphoria.

ii. Brow reconstruction/brow lift;

iii. Cheek augmentation;

iv. Forehead contouring (including forehead reshaping or forehead reduction);

v. Genioplasty (chin augmentation, chin reconstruction, or chin reduction/narrowing);

vi. Scalp/hairline advancement;

vii. Lateral canthopexy;

viii. Surgical lip lift;

ix. Lysis intranasal synechiae;

x. Mandibuloplasty;

xi. Osteoplasty;

xii. Rhinoplasty and septoplasty;

xiii. Rhytidectomy (facelift surgery) of the forehead, cheek, and/or neck (platysmaplasty);

xiv. Suction-assisted lipectomy in conjunction with medically necessary facial procedures;

Note: See the Limitations and Exclusions section for Plan guidelines for suction-assisted lipectomy NOT related to medically necessary facial procedures, as well as clinical guidelines for liposuction and/or lipofilling as a gender affirmation procedure.

xv. Tracheoplasty/tracheal shave; AND/OR

2. Hair Removal with Laser or Electrolysis:

The following applicable criteria must be met in item a and/or item b:

a. Electrolysis and/or laser treatments for **face and neck hair removal** performed by a licensed and qualified treating clinician are considered medically necessary when ALL criteria are met in items (1) through (7):

(1) Criteria are met for items A and B above; AND

(2) A licensed qualified health professional recommends hair removal of the face and/or neck as part of the member's medically necessary treatment for gender dysphoria; AND

(3) A letter from the clinician performing the hair removal is submitted to the Plan and includes attestation of the medical necessity of hair removal and a summary of the member's care as it relates to gender dysphoria treatment; AND

(4) Documentation submitted to the Plan includes the area size and location(s) for permanent hair removal, the type of hair removal treatment (laser or electrolysis), and the expected timeframe and number of treatments requested. The Plan will authorize medically necessary requests for electrolysis and/or laser ablation treatments for medically necessary permanent hair removal of the face and/or neck for up to **12 calendar months** from the date of the authorization request. Additional treatments require a separate Plan authorization; AND

(5) The clinician performing the hair removal has collaborated with any other health care professionals involved in the member's care, including, but not limited to, the member's primary care clinician and behavioral health provider; AND

(6) The clinician performing the hair removal has discussed risks and complications of the proposed procedure, including the clinician's own complication rates, and has obtained informed consent from the member; AND

(7) The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals unless hormone therapy is medically contraindicated; OR

b. Hair removal for standard pre-operative preparation for genital gender affirmation surgery:

Electrolysis and/or laser treatments for hair removal performed by a licensed and qualified treating provider are considered medically necessary when it is part of the **standard pre-operative preparation for genital gender affirming surgery(ies)** for members with persistent, well-documented gender dysphoria and ALL criteria are met in items (1) through (7):

(1) Criteria are met for items A and B above; AND

(2) Permanent hair removal is required as part of the standard pre-operative preparation for genital affirming surgery(ies) and is recommended by the treating

surgeon, with documentation verifying that hair removal is medically necessary; AND

(3) A letter from the clinician performing the hair removal is submitted to the Plan and includes attestation of the medical necessity of hair removal and a summary of the member's care as it relates to gender dysphoria treatment; AND

(4) Documentation submitted to the Plan includes the area size and location(s) for permanent hair removal, the type of hair removal treatment (laser or electrolysis), expected timeframe and number of treatments requested, and the estimated date of the genital gender affirmation surgical procedure(s). The Plan will authorize medically necessary requests for electrolysis and/or laser ablation treatments for medically necessary pre-operative permanent hair removal as standard preparation for genital gender affirmation surgery for up to **18 calendar months** from the date of the authorization request. Additional treatments require a separate Plan authorization; AND

(5) The clinician performing the hair removal has collaborated with any other health care professionals involved in the member's care, including, but not limited to, the member's primary care clinician and behavioral health provider; AND

(6) The clinician performing the hair removal has discussed risks and complications of the proposed procedure, including the clinician's own complication rates, and has obtained informed consent from the member; AND

(7) ANY criteria in item (a) or item (b) is met:

(a) Applicable criteria are met and the genital gender affirmation surgical procedure requiring pre-operative hair removal is authorized by the Plan; OR

(b) An **evaluation note from the treating surgeon** documents the medical necessity of both the genital gender affirmation surgery(ies) and permanent hair removal for pre-operative preparation for the member when the Plan has NOT received a prior authorization request for the genital gender affirmation surgical procedure(s) scheduled greater than **18 calendar months** from the requested hair removal treatments.

Prior authorization for the requested genital gender affirmation procedure(s) is NOT required for the Plan to authorize medically necessary permanent hair removal in preparation for the genital surgical procedure(s). Examples include perineal hair removal prior to vaginoplasty and the removal of hair on a skin graft for its use in gender affirming genital reconstruction surgery but it must be approved by a Plan Medical Director (e.g., hair removal on skin graft donor site prior to its use for vaginoplasty as a feminizing procedure for the treatment of gender dysphoria or hair

removal on skin graft donor site prior to its use for phalloplasty as a masculinizing procedure for the treatment of gender dysphoria).

Limitations and Exclusions

When Plan Medical Director review is required, individual consideration based on the guidelines specified in the Plan's *Clinical Review Criteria* administrative policy, policy number OCA 3.201, and according to the documentation submitted by the treating provider and included in the member's medical record.

1. Plan Medical Director review is required for gender affirmation surgery(ies) requested for a member who does NOT meet DSM-5 criteria for gender dysphoria (e.g., non-binary members who do not meet traditional diagnostic criteria for gender dysphoria).

2. If a member is unable to successfully live full-time in the gender role that is congruent with the member's gender identify as a real-life experience (with no returning to the member's original gender), Plan Medical Director review and approval will be required for each requested gender affirmation surgical procedure. This includes members who identify as genders other than male or female. The treating provider must submit documentation indicating why it would be clinically inappropriate to require the member to meet this criterion and why this requirement should be waived. All other applicable medical necessity criteria must be met for the requested gender affirmation surgery(ies).

3. External review will be available to the members enrolled in Qualified Health Plans, ConnectorCare, or Employer Choice Direct products when the Plan determines that coverage for treatment of gender dysphoria is NOT medically necessary or the Plan considers the treatment experimental or investigational. Like external reviews for other types of medical services and treatments, the external review for Qualified Health Plans, ConnectorCare, or Employer Choice Direct products will be based upon the Massachusetts definition of medical necessity. (Source: The Commonwealth of Massachusetts, Health Policy Commission, Memo: External Review for Denials of Coverage for Medical and/or Surgical Treatment of Gender Dysphoria, July 2, 2015.)

4. Plan Medical Director review is required when gender affirmation surgery is requested for a Plan member under the age of 18 on the date of service.

5. Plan Medical Director review is required for requests for mastopexy when used for the treatment of gender dysphoria. Breast reconstruction used for the treatment of members with persistent, well-documented gender dysphoria may include the medically necessary surgical removal of breast implants and/or the replacement of breast implants after implant explantation (including when the implant was initially inserted as a component of a gender affirmation surgery); review the criteria in the Clinical Criteria section of the *Breast*

Reconstruction medical policy, policy number OCA 3.43, rather than the criteria included in this policy.

6. The Plan considers any services or surgical procedures used to reverse gender affirmation surgery(ies) to NOT be medically necessary. Requests for reversal or revision of a previous gender affirmation surgery will be reviewed individually by a Plan Medical Director.

7. When a surgical revision of a previously performed gender affirmation surgery is requested for a Plan member, Plan Medical Director review and approval are required. A Plan Medical Director will verify the medical necessity of the requested the surgical revision and verify that the procedure is requested to correct a complication resulting from the initial gender affirmation surgery (e.g., infection), to correct a functional impairment resulting from the initial gender affirmation surgery, and/or the revision is required as a component of the member's medically necessary staged reconstructive surgical treatment plan (e.g., neovaginoplasty, phalloplasty, chest reconstruction).

8. The Plan considers gender affirmation surgery medically necessary for a definitive diagnosis of persistent, well-documented **gender dysphoria** when the Plan's applicable medical necessity guidelines are met and according to the member's benefit coverage. Plan Medical Director prior authorization review and approval will be required for individual consideration for gender incongruence when the member's diagnosis does NOT meet the definition of gender dysphoria.

9. Hair removal is ONLY covered when criteria are met in the Clinical Criteria section for the method of hair removal (i.e., electrolysis and/or laser hair removal). Any other method of hair removal or indication for treatment is NOT covered.

10. The Clinical Criteria section includes procedures and treatments considered medically necessary for the treatment of gender dysphoria when applicable clinical review criteria are met. The following procedures/services in items a through q are NOT covered for the treatment of gender dysphoria:

    a. Blepharoplasty (eyelid surgery) NOT in conjunction with other facial feminization or facial masculinization procedures used for the treatment of gender dysphoria; OR

    b. Body contouring procedures, including abdominoplasty, liposuction, lipofilling, and/or suction-assisted lipectomy UNLESS the treatment is listed as medically necessary in the Clinical Criteria section (e.g., facial procedures for the treatment of gender dysphoria) and ALL applicable clinical review criteria are met for the gender affirmation surgical procedure; OR

    c. Calf augmentation (calf implants); OR

d. Collagen injections; OR

e. Facial feminization surgery, facial masculinization surgery, facial bone reduction, or facial implants or injections UNLESS the treatment is specified as medically necessary in the Clinical Criteria section and applicable clinical review criteria are met for the facial feminizing or facial masculinizing gender affirmation surgical procedure; OR

f. Gluteal augmentation (gluteal implants and/or lipofilling); OR

g. Hair transplantation or hair reconstruction (see the Clinical Criteria section for guidelines for hairline advancement surgery); OR

h. Laryngoplasty (technique to alter the voice tract and adjust vocal range); OR

i. Lip reduction or lip enhancement (see the Clinical Criteria section for guidelines related to lip lift); OR

j. Osteoplasty UNLESS clinical review criteria are met for the facial feminization or facial masculinization gender affirmation surgical procedure in the Clinical Criteria section); OR

k. Otoplasty (surgical reshaping of the outer ear);

l. Pectoral augmentation (pectoral implants); OR

m. Removal of redundant skin including but NOT limited to panniculectomy and/or abdominoplasty when used for the treatment of gender dysphoria UNLESS the procedure is listed as medically necessary in the Clinical Criteria section and applicable criteria are met; OR

   Note: Review the Plan's clinical review criteria for the requested procedure. See the Plan's medical necessity guidelines included in the *Panniculectomy and Related Redundant Skin Surgery* medical policy, policy number OCA 3.722.

n. Silicone injections of the breast; OR

o. Skin resurfacing treatments including but NOT limited to chemical peels and/or dermabrasion; OR

p. Tattooing; OR

q. Vocal cord surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords); OR

11. Laparoscopic prostatectomy as a component of gender affirmation surgical procedure(s) requires Plan Medical Director review.

12. Post-operative lodging is NOT routinely covered by the Plan; Plan Medical Director review is required for individual consideration.

13. Reimbursement for travel expenses is NOT covered by the Plan unless the Plan's product-specific criteria are met, as specified in the *Ambulance and Transportation Services* medical policy applicable for the member's product, policy number OCA 3.191.

14. Infertility Services Before a Member Undergoes Medical Treatment Expected to Result in Permanent Infertility:

    Feminizing/masculinizing hormonal therapy and/or gender affirmation surgeries may limit the member's fertility. Infertility services are covered for some Plan products. Review the Plan's *Infertility Services* medical policy, policy number OCA 3.725 for clinical review criteria used to determine the medical necessity of infertility services before a member undergoes medical treatment that is expected to result in permanent infertility (e.g., hormone therapy for the treatment of gender dysphoria or genital gender affirmation surgery) when it is a covered service for the member.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 140.9 states CMS has determined that no NCD is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with gender dysphoria. LCA A53793 includes billing, coding, and treatment guidelines for gender reassignment services for gender dysphoria. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare &

Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria and Limitations and Exclusions sections of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

ICD-10 Codes	**Description: The following primary diagnosis codes apply to gender dysphoria and require prior authorization when billed with a medically necessary procedure code covered by the Plan for gender affirmation surgeries, hair removal, and/or voice therapy, as specified below.** Each gender affirmation surgery requires Plan prior authorization for ALL diagnosis and procedure codes, even if coding is not included in this Applicable Coding section. See the member's applicable benefit document to determine coverage of services. Plan Medical Director review is required for each gender affirmation surgery when the member has a diagnosis of gender incongruence (without a diagnosis of gender dysphoria) for individual consideration.
F64.0-F64.9	Gender identity disorders
Z87.890	History of sex reassignment surgery

CPT Codes	**Description: Services considered medically necessary for the treatment of gender dysphoria if Plan clinical review criteria are met (when billed with a primary ICD-10 diagnosis code listed above). Prior authorization is required.**
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck,

	axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead Plan note: Code is NOT payable for the MassHealth and QHP products.
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) Plan note: Code is NOT payable for the MassHealth and QHP products.
15826	Rhytidectomy; glabellar frown lines Plan note: Code is NOT payable for MassHealth and QHP products.
15828	Rhytidectomy; cheek, chin, and neck Plan note: Code is NOT payable for MassHealth and QHP products.
15876	Suction assisted lipectomy; head and neck
19301	Mastectomy partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant Plan note: Breast reconstruction for male-to-female members with persistent, well-documented gender dysphoria may include the medically necessary surgical removal of breast implants and/or the replacement of breast implants after implant explantation (including when the implant was initially inserted as a component of a gender affirmation surgery); review the criteria in the *Breast Reconstruction* medical policy, policy number OCA 3.43, rather than the criteria included in this policy for Plan prior authorization guidelines for these surgical procedures.
19350	Nipple/areola reconstruction

21120	Genioplasty; augmentation (autograft, allograft, prosthetic material) Plan note: Code is NOT payable in the outpatient setting for the MassHealth and QHP products.
21121	Genioplasty; sliding osteotomy, single piece Plan note: Code is NOT payable in the outpatient setting for the MassHealth and QHP products.
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin) Plan note: Code is NOT payable in the outpatient setting for the MassHealth and QHP products.
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) Plan note: Code is NOT payable in the outpatient setting for the MassHealth and QHP products.
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes

	obtaining autografts)
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21270	Malar augmentation, prosthetic material
21282	Lateral canthopexy
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and

	alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum and osteotomies
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30560	Lysis intranasal synechia
31599	Unlisted procedure, trachea, bronchi
31750	Tracheoplasty; cervical Plan note: Code used for trachea shaving for male-to-female transition.
40799	Unlisted procedure, lips Plan note: Code used for lip lift.
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra Plan note: Code is NOT payable in the outpatient setting for MassHealth, QHP, and Senior Care Options products.
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54120	Amputation of penis; partial
54125	Amputation of penis; complete Plan note: Code is NOT payable in the outpatient setting for the MassHealth, QHP, and Senior Care Options (SCO) products.
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component inflatable penile prosthesis, including placement of pump, cylinders, and reservoir

54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female Plan note: Series of staged procedures to remove penis and create vagina.
55980	Intersex surgery; female to male Plan note: Series of staged procedures to remove or close vagina and for penis and testicles.
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, non-obstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy, complete removal of vaginal wall Plan note: Code is NOT payable in the outpatient setting for the MassHealth, QHP, and SCO products.
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) Plan note: Code is NOT payable in the outpatient setting for the MassHealth, QHP, and SCO products.
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) Plan note: Code is NOT payable in the outpatient setting for the MassHealth, QHP, and Senior Care Options products.
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy) with or without removal of tube(s), with or without removal of ovary(s) Plan note: Code is NOT payable in the outpatient setting for the MassHealth,

	QHP, and SCO products.
58260	Vaginal hysterectomy, for uterus 250g or less
58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy Plan note: Code is NOT payable in the outpatient setting for the MassHealth, QHP, and SCO products.
58290	Vaginal hysterectomy, for uterus greater than 250g
58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical with vaginal hysterectomy, for uterus greater than 250g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure); with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) Plan note: Code is NOT payable in the outpatient setting for the MassHealth, QHP, and SCO products.

58940	Oophorectomy, partial or total, unilateral or bilateral Plan note: Code is NOT payable in the outpatient setting for the MassHealth, QHP, and SCO products.
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

HCPCS Code	**Description: Service is considered medically necessary for the treatment of gender dysphoria if Plan criteria are met and is billed with a primary ICD-10 diagnosis code listed above. Prior authorization is required.**
L8600	Implantable breast prosthesis, silicone or equal

CPT Codes	**Description: The following services require Plan Medical Director review and approval when used for the treatment of gender dysphoria (and billed with a primary ICD-10 diagnosis code listed above). Prior authorization is required.**
19316	Mastopexy Plan note: Code is NOT payable in the outpatient setting for MassHealth and QHP products.
19380	Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
31587	Laryngoplasty, cricoid split, without graft placement Plan note: Code is NOT payable in the outpatient setting for MassHealth and QHP products.
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed Plan note: Code is NOT payable in the outpatient setting for MassHealth and QHP products.
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach Plan note: Code is NOT payable in the outpatient setting for MassHealth, QHP, and SCO products.
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

CPT Codes	Description: Coverage guidelines based on the indication for treatment and type of service provided (when billed with a primary ICD-10 diagnosis code listed above for gender dysphoria). Prior authorization is required.
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue Plan note: Code used when billing for laser ablation for hair removal on a skin graft donor site for a genital gender affirmation surgery.

CPT Codes	Description: Voice therapy is considered medically necessary for the treatment of gender dysphoria. Plan notification is required when the following CPT codes are billed with a primary ICD-10 diagnosis code listed above for gender dysphoria.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals

CPT Codes	Description: Services NOT considered medically necessary for the treatment of gender dysphoria (and billed with a primary ICD-10 diagnosis code listed above). Prior authorization is required.
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10 cc or less
11954	Subcutaneous injection of filling material (e.g., collagen); over 10 cc
15775	Punch graft for hair transplant; 1-15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15830	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh

15833	Excision, excessive skin and subcutaneous tissue (including lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (including lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (including lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (including lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by

Regulatory Approval: N/A Internal Approval: 03/18/15: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 04/08/15: Quality Improvement Committee (QIC)	07/01/15 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 07/01/17
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy title *Gender Reassignment Surgery* from 01/01/16 to 05/31/18. Policy title changed to *Gender Affirmation Surgeries* from 06/01/18 to 12/31/21. Policy title changed to *Gender Affirmation Services* as 01/01/22 because policy includes guidelines for gender affirmation surgeries, hair removal, and voice therapy.

Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
09/01/15	Review for effective date 01/01/16. Updated criteria in the Medical Policy Statement and Limitations sections. Removed requirement for 18 months of treatment for gender dysphoria. Added guidelines on external review for services denied by the Plan when members are enrolled in Qualified Health Plans, ConnectorCare, and/or Employer Choice Direct products. Update the Summary, Clinical Background Information, Definitions, and References sections and the list of applicable products.	01/01/16 Version 2	09/16/15: MPCTAC 10/14/15: QIC
11/25/15	Review for effective date 01/01/16. Updated language in the Applicable Coding section.	01/01/16 Version 3	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 08/01/16. Revised the Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Removed ICD9 codes, added CPT code 17380 as applicable code, and added a Plan not in the Applicable Coding section. Revised criteria in the Medical Policy Statement and Limitations sections.	08/01/16 Version 4	04/20/16: MPCTAC 05/23/16: QIC
07/05/16	Review for effective date 10/01/16. Revised	10/01/16	07/05/16: MPCTAC

Policy Revisions History			
	criteria in the Medical Policy Statement and Limitations section. Revised the applicable code list and added Plan notes to codes. Updated Summary and References sections.	Version 5	(electronic vote) 07/13/16: QIC
09/01/16	Review for effective date 10/01/16. Added reference to the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) effective 08/30/16 in the Clinical Background Information and References sections. CMS industry-wide update with no change to criteria and/or the applicable code list for Plan members (including members enrolled in a SCO product).	10/01/16 Version 6	Not applicable because industry-wide update of CMS guidelines with no change to criteria and/or the applicable code list
09/28/16	Review for effective date 11/01/16. Administrative changes made to clarify language related to gender. Revised Definitions section.	11/01/16 Version 7	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
06/01/17	Review for effective date 07/01/17. Added the WellSense New Hampshire Medicaid product as applicable new product for this policy as of 07/01/17 with the necessary administrative changes made to the Medical Policy Statement, Summary, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. WellSense New Hampshire Medicaid criteria added in product-specific Medical Policy Statement section and product-specific Limitations section.	07/01/17 Version 8	06/21/17: MPCTAC
05/01/17	Review for effective date 08/01/17. Criteria for BMC HealthNet Plan products were revised in the Medical Policy Statement section in 05/17 (with adequate provider notification); new criteria are effective 08/01/17 for BMC HealthNet Plan products. Administrative changes made to the Summary, Definitions, and References sections.	08/01/17 Version 9	05/17/17: MPCTAC
06/01/17	Review for effective date 08/01/17. Administrative change made to combine criteria in the Medical Policy Statement sections and in the Limitations sections for all BMC HealthNet Plan products and WellSense New Hampshire Medicaid product (since all criteria are consistent among Plan products as of 08/01/17). Administrative change made to the Limitations section to be consistent with the Applicable Coding section.	08/01/17 Version 10	06/21/17: MPCTAC
03/01/18	Review for effective date 06/01/18. Revised policy	06/01/18	03/21/18: MPCTAC

Policy Revisions History			
	title. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections. Coding updated and Plan notes revised in the Applicable Coding section.	Version 11	
05/01/19	Review for effective date 08/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Criteria updated in the Medical Policy Statement and Limitations sections. Coding updated in the Applicable Coding section.	08/01/19 Version 12	05/15/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide update to coding (as a code deletion) included in the Applicable Coding section.	01/01/20 Version 13	Not applicable because industry-wide code changes
04/01/20	Review for effective date 08/01/20. Administrative changes made to the Definitions, References, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections. Coding updated in the Applicable Coding section.	08/01/20 Version 14	04/15/20: MPCTAC
12/01/20	Review for effective date 01/01/21. Industry-wide updates to coding in the Applicable Coding section. Administrative changes made to the Limitations and Other Applicable Policies sections.	01/01/21 Version 15	Not applicable because industry-wide code changes; 12/16/20: MPCTAC review
01/01/21	Review for effective date 02/01/21. Revised criteria in the Medical Policy Statement section.	02/01/21 Version 16	01/22/21: MPCTAC (electronic vote)
04/01/21	Review for effective date 07/01/21. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Updated the applicable code list.	07/01/21 Version 17	04/21/21: MPCTAC
10/01/21	Review for effective date 01/01/22. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made	01/01/22 Version 18 Version 18 replaced with version 19 as of	10/20/21: MPCTAC

Policy Revisions History			
	to the Policy Summary and References sections. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections. Coding revised in the Applicable Coding section.	01/01/22 and version 18 not implemented	
11/01/21	Review for effective date 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations, and Applicable Coding sections. Criteria and coding for voice therapy used for the treatment of gender dysphoria moved from the Plan's speech therapy medical policies to this policy with Plan notification (rather than prior authorization) required when applicable coding guidelines followed. Revised policy title.	01/01/22 Version 19 Version 19 replaced version 18 as of 01/01/22 and all revisions in version 18 adopted	11/30/21: MPCTAC (electronic vote)

Next Review Date

04/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: [+]

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.