Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Gender Affirming Services

Effective: February 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816

☒ Tufts Health Plan Commercial products; 617-972-9409

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404

☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Gender-affirming surgery (GAS) refers to one or more procedures that are part of a multi-disciplinary treatment plan involving medical, surgical, and behavioral health interventions available for treatment of transgender and gender diverse (TGD) individuals. Transgender and gender diverse are broad terms that describe individuals with gender identifies or expressions that differ from assigned sex at birth. Gender affirming surgery can include chest surgery, genital surgery, facial surgery, and other procedures aimed at helping a TGD individual transition to their self-identified gender. It is recommended that gender affirming procedures should only be performed when the experience of gender incongruence is marked and sustained.

Note: For Members under the age of 18 see section below: ***Gender Affirming Surgery for Members Under the Age of 18***

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan Members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations. NCD - Gender Dysphoria and Gender Reassignment Surgery (140.9) (cms.gov) and Gender-Affirming Care for MassHealth Members | Mass.gov and is being supplemented by guidelines from the World Professional Association for Transgender Health (WPATH) Standards of Care. WPATH guidelines provide additional detail regarding medical necessity criteria.

For gender affirming services, evidence is sufficient for coverage. In addition to the coverage of gender affirming procedures that are covered through the NCD and MassHealth, evidence is also sufficient for coverage of the following: surgery for Members less than 18 years of age, surgery for Members who have been diagnosed with gender dysphoria/gender incongruence based on an evaluation by one Qualified Health Care Professional, and vocal cord surgery. WPATH is an interdisciplinary professional and educational organization responsible for producing evidence-based guidelines for gender affirming services such as behavioral, medical, and surgical management of gender diverse health.

The use of this supplemented criteria in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

Clinical Guideline Coverage Criteria

Genital Surgery Clinical Coverage Criteria

The Plan considers surgical services as medically necessary when documentation and letters confirm **ALL** the following for gender affirming **genital surgery**:

1. Member has been diagnosed with gender dysphoria/gender incongruence based on an evaluation by one Qualified Health Care Professional who has competencies in the assessment of transgender and gender diverse people and attests to the Member's readiness for medical/surgical treatments; **and**
2. Other possible causes for gender incongruence have been identified and excluded; **and**
3. New self-identified gender has been present for more than 12 months and Member has lived as their affirmed gender if safe to do so; **and**
4. Co-morbid medical or behavioral health conditions that could negatively impact the outcome of gender-affirming treatments have been assessed and are reasonably controlled; **and**
5. Member has the capacity to make fully informed decisions and to consent to treatment; **and**
6. Member has completed at least six months of continuous hormone therapy as appropriate to the Member's gender goals (12 months for adolescents less than 18 years of age), unless hormone therapy is not desired or medically contraindicated (Numbers 3 and 6 may occur concurrently).

When the above criteria are met, the following genital surgical procedures to treat Gender Dysphoria are medically necessary:

- Hysterectomy
- Salpingo-oophrectomy
- Vulvectomy
- Vaginectomy
- Urethroplasty
- Metoidioplasty
- Phalloplasty*
- Penile Prosthesis
- Placement of Testicular Prosthesis
- Scrotoplasty
- Penectomy
- Clitoroplasty
- Colovaginoplasty
- Vulvoplasty
- Labiaplasty
- Orchiectomy
- Vaginoplasty

***Note**: Given the high rates of complications and complexity of phalloplasty surgery as compared to other gender-affirming procedures, phalloplasty is limited to those Members aged 18 and above

Chest Surgery Clinical Coverage Criteria

The Plan considers surgical services as medically necessary when documentation and letters confirm **ALL** the following for gender affirming **breast/chest surgery**:

1. Member has been diagnosed with gender dysphoria/gender incongruence based on an evaluation by one Qualified Health Care Professional who has competencies in the assessment of transgender and gender diverse people and attests to the Member's readiness for medical/surgical treatments; **and**
2. Other possible causes for gender incongruence have been identified and excluded; **and**
3. New self-identified gender has been present for more than 12 months and Member has lived as their affirmed gender if safe to do so; **and**
4. Co-morbid medical or behavioral health conditions that could negatively impact the outcome of gender-affirming treatments have been assessed and are reasonably controlled; **and**
5. Member has the capacity to make fully informed decisions and to consent to treatment; **and**
6. For feminizing gender affirming chest surgery only, Member has completed at least six months of feminizing hormone therapy prior to breast augmentation surgery (12 months for adolescents less than 18 years of age), unless hormone therapy is not desired or medically contraindicated; **and**
7. Risk factors associated with breast cancer have been assessed.

Note: For transmasculine members requesting surgical chest procedures, hormone therapy is not required.

When the above criteria are met, the following breast/chest surgery surgical procedures to treat Gender Dysphoria are medically necessary:

- Mastectomy (bilateral)
- Mammoplasty (breast augmentation)

Facial Feminization or Masculinization Surgeries

The Plan considers surgical services as medically necessary when documentation and letters confirm **ALL** of the following for gender affirming **facial surgery**:

1. Member has been diagnosed with gender dysphoria/gender incongruence based on an evaluation by one Qualified Health Care Professional who has competencies in the assessment of transgender and gender diverse people and attests to the Member's readiness for medical/surgical treatments; **and**
2. Other possible causes for gender incongruence have been identified and excluded; **and**
3. New self-identified gender has been present for more than 12 months and Member has lived as their affirmed gender if safe to do so; **and**
4. Co-morbid medical or behavioral health conditions that could negatively impact the outcome of gender-affirming treatments have been assessed and are reasonably controlled; **and**
5. Member has the capacity to make fully informed decisions and to consent to treatment.

When the above criteria are met, the following facial feminization or masculinization surgical procedures to treat Gender Dysphoria are medically necessary:

- Blepharoplasty
- Brow Lift
- Cheek Augmentation
- Forehead and mandible/jaw contouring and reduction
- Grafting of autologous tissue
- Genioplasty
- Hairline advancement
- Lateral canthopexy
- Lip lift
- Lysis intranasal synechia
- Osteoplasty
- Rhinoplasty
- Suction assisted lipectomy
- Tracheoplasty
- Reduction thyroid chondroplasty

Hair Removal for Face/Neck

The Plan considers hair removal by laser or electrolysis for the face and neck as medically necessary when documentation and letters confirm **ALL** the following:

1. Member has been diagnosed with gender dysphoria/gender incongruence based on an evaluation by one Qualified

Health Care Professional who has competencies in the assessment of transgender and gender diverse people and attests to the Member's readiness for medical/surgical treatments; **and**

2. Other possible causes for gender incongruence have been identified and excluded; **and**
3. New self-identified gender has been present for more than 12 months and Member has lived as their affirmed gender if safe to do so; **and**
4. Co-morbid medical or behavioral health conditions that could negatively impact the outcome of gender-affirming treatments have been assessed and are reasonably controlled; **and**
5. Member has the capacity to make fully informed decisions and to consent to treatment; **and**
6. Member has completed at least six months of continuous hormone therapy as appropriate to the member's gender goals (12 months for adolescents less than 18 years of age), unless hormone therapy is not desired or medically contraindicated.

Hair Removal for Genital Surgery

The Plan considers hair removal by laser or electrolysis for planned gender affirming surgical services as medically necessary when documentation and letters confirm **ALL** of the following:

1. Member has been diagnosed with gender dysphoria/gender incongruence based on an evaluation by one Qualified Health Care Professional who has competencies in the assessment of transgender and gender diverse people and attests to the Member's readiness for medical/surgical treatments; **and**
2. Other possible causes for gender incongruence have been identified and excluded; **and**
3. New self-identified gender has been present for more than 12 months and Member has lived as their affirmed gender if safe to do so; **and**
4. Co-morbid medical or behavioral health conditions that could negatively impact the outcome of gender-affirming treatments have been assessed and are reasonably controlled; **and**
5. Member has the capacity to make fully informed decisions and to consent to treatment; **and**
6. Member has completed at least six months of continuous hormone therapy as appropriate to the member's gender goals (12 months for adolescents less than 18 years of age), unless hormone therapy is not desired or medically contraindicated; **and**
7. Prior authorization must be obtained for gender affirming surgery prior to request for hair removal.

Note: Documentation must include a letter of medical necessity by the treating surgeon, indicating the size and location of the area to be treated, a timeline with the expected number of treatments and expected date of planned genital surgery.

Speech Therapy

The Plan considers voice modification and communication therapy by a licensed speech-language pathologist for a definitive diagnosis of persistent gender dysphoria as medically necessary for development of vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., facial expressions, laughing) that are congruent with the member's gender identity and/or gender expression.

Vocal Cord Surgery for Voice Feminization (Glottoplasty)

The Plan considers vocal cord surgery as medically necessary for planned gender affirming surgical services when documentation and letters confirm **ALL** of the following:

1. Member has been diagnosed with gender dysphoria/gender incongruence based on an evaluation by one Qualified Health Care Professional who has competencies in the assessment of transgender and gender diverse people and attests to the Member's readiness for medical/surgical treatments; **and**
2. Other possible causes for gender incongruence have been identified and excluded; **and**
3. New self-identified gender has been present for more than 12 months and Member has lived as their affirmed gender if safe to do so; **and**
4. Co-morbid medical or behavioral health conditions that could negatively impact the outcome of gender-affirming treatments have been assessed and are reasonably controlled; **and**
5. Member seeks to make their voice and/or other aspects of their communication congruent with their gender identity and/or gender expression and has the capacity to make fully informed decisions and to consent to treatment; **and**
6. Surgery to be performed by a Ear Nose and Throat (ENT) specialist; **and**
7. Documentation of pre-surgical voice lessons and/or therapy by a licensed speech-language pathologist.

Gender Affirming Surgery for Members Under the Age of 18

Gender affirming medical or surgical procedures for a Member under 18 years of age may be medically necessary when the above criteria are met for the specific surgical procedure requested. In addition, **ALL** of the following criteria must be

met:

1. There is written documentation and letters (one letter may suffice) confirming a multidisciplinary team has assessed the Member and it is the opinion of two Qualified Health Professionals that the Member is ready for surgery; **and**
2. Depending upon the type of surgery requested, the adolescent had been informed of the reproductive effects, including the potential loss of fertility, and available options to preserve fertility; **and**
3. An assessment of the minors emotional and cognitive maturity is required to provide informed consent/assent for the treatment; **and**
4. Involvement of parent(s)/guardian(s) in the assessment/consent process is required unless their involvement is determined to be harmful to the adolescent or not feasible.

Limitations

The Plan considers all other services for the treatment of gender dysphoria/gender incongruence as not medically necessary for all other indications. In addition, the Plan does not cover:

1. Body contouring procedures e.g., abdominoplasty, panniculectomy, lipofilling
2. Collagen injections
3. Dermabrasion
4. Chemical peels
5. Electrolysis or hair removal except for face/neck and when required pre-operatively for genital surgery and when policy criteria are met
6. Hair transplantation
7. Implantations (e.g., calf, pectoral, gluteal)
8. Panniculectomy
9. Removal of redundant skin
10. Silicone injections (e.g., for breast enlargement)
11. Reimbursement for travel expenses

Note: Reconstructive surgery following gender affirmation procedures may be considered medically necessary to correct complications from the initial surgery or to correct functional impairment as a result of the initial surgery. When additional surgery has been recommended by a treating physician in order to decrease the Member's dysphoria, surgery may be considered medically necessary. Surgery for the purpose of reversing the appearance of normal aging or for cosmetic purposes are considered not medically necessary.

Supporting Information

Characteristics of a Qualified Health Care Professional (WPATH SOC-8)

Qualifications of Health Care Professional for assessing transgender and gender diverse adults for physical treatments (from WPATH SOC-8):

1. Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
2. For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.
3. Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
4. Are able to assess capacity to consent for treatment.
5. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
6. Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.

Note: WPATH suggests health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment liaise with professionals from different disciplines within the field of transgender health for consultation and referral.

Note: Qualified Health Care Professional can include licensed psychologist, psychiatrist, social worker, or other licensed physician credentialed in the field.

Characteristics of Health Care Professionals working with gender diverse adolescents (WPATH SOC-8)

1. Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.

2. Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.
3. Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.
4. Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
5. Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.

Note: Qualified Health Care Professional can include licensed psychologist, psychiatrist, social worker, or other licensed physician credentialed in the field

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
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
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, 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)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 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
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction

Code	Description
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
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
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)
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)
31599	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
40799	Unlisted procedure, lips
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
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
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
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
55899	Unlisted procedure, male genital system
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete

Code	Description
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall;
57110	Vaginectomy, complete removal of vaginal wall;
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);
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g 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 250 g;
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 removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;
58999	Unlisted procedure, female genital system (nonobstetrical)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Table 2: ICD-10 Codes

CPT codes listed require prior authorization when submitted with the following ICD-10 CM diagnosis codes

Codes	Description
F64-F64.9	Gender identity disorder
Z87.890	Personal history of sex reassignment

References:

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10. Lai A, Johnson R. World Professional Association for Transgender Health Guidelines: 2022 surgical treatment updates in the standards of care for transgender and gender diverse people [published online ahead of print, 2022 Dec 7]. Neurourol Urodyn. 2022;10.1002/nau.25099. doi:10.1002/nau.25099.
11. Sex Reassignment Surgery for the Treatment of Gender Dysphoria. Hayesinc.com/login [via subscription only]. Published August 1, 2018. Updated August 22, 2019. Accessed March 8, 2021.
12. UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. transcare.ucsf.edu/guidelines. Accessed March 14, 2023.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC. In clinical coverage criteria, clarified treating providers includes both medical and/or surgical providers. The following codes added: 58570, 15771, 15772, 67900

Subsequent endorsement date(s) and changes made:

- March 17, 2021: Reviewed by IMPAC. Terminology change from gender reassignment surgery or sexual reassignment surgery to gender affirmation or confirmation surgery; references updated
- June 16, 2021: Reviewed by IMPAC. Under Limitations, changed “Body contouring procedures” to “Body changes not associated with gender transition procedures”
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan with an effective date of September 1, 2021. Title change to Gender Affirming Services and new criteria added for speech therapy, hair removal from face/neck, etc. Codes added: 11970, 11971, 15876, 21208, 21210, 30520, 31750, 54400, 54401, 54405 and 55866 removed. Public plans to follow this policy and the Medical Necessity Guidelines for Transgender Surgical Procedures for Tufts Health Together and Tufts Health RITogether will be retired
- February 1, 2022: Template Updated
- June 15, 2022: Reviewed by MPAC for an effective date of October 1, 2022. Addition of gender affirming genital surgery recommended by two treating clinicians and breast/chest surgery recommend by one treating clinician. Addition of codes 55980, 40799, and 21282
- June 21, 2023: Reviewed by MPAC; criteria updated to align with updates to World Professional Association for Transgender Health (WPATH) standards of care. Codes 57295, 57296, and 57426 will no longer require prior authorization. Prior authorization will now be required for 55899, 58999, 14301, 14302, 15773, 15774, 15877, 15878, 15879, 56620, 53410, 54300, 56810. Effective October 1, 2023
- November 4, 2023: Coding updated to require PA for 17380 for Harvard Pilgrim Health Care plans effective February 1, 2024
- November 2023: Rebranded Unify to One Care and updated overview, effective January 1, 2024

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.