Gender Affirming Care Criteria

Policy Number: PA 29
Last Review Date: 12/07/2023
Effective Date: 1/1/2024

Policy

Maryland Care, Inc., dba Maryland Physicians Care (MPC) covers gender affirming treatment or surgery if specific criteria are met. MPC follows the Maryland Medical Assistance requirements for nondiscriminatory criteria.

MPC requires Prior Authorization (PA) for all gender affirming care covered benefits.

All requests for any Gender Affirming Care must include:

1. Informed Consent
    a. Informed consent is required.
    b. Parental or guardian consent is required for members under the age of 18 as per MPC policy 8000.33 Consent to Treat Minors.
2. Documentation of Medical Necessity, at least
    a. For Adults: At least one letter of assessment from a Somatic Healthcare Professional (SHP) who has competencies in the assessment of transgender and gender diverse people is required to recommend gender affirming medical and surgical treatment.
    b. For Adolescents: At least one letter of assessment from an SHP or a Mental Health Professional (MHP) who is a member of a multidisciplinary team is required. This letter needs to reflect the assessment and opinion from the team that involves both somatic and mental health professionals.
3. Transgender Affirming Care Providers must be:
    a. SHP must meet all of the following criteria:
        i. Must possess one of the following degrees: MD, DO, NP.
        ii. Trained in gender-affirming care and have knowledge about gender diverse identities and expressions as attested by the provider.
    b. MHP must meet all of the following criteria:
        i. Must be a mental health professional with one of the following degrees: Ph.D., MD, DO, Ed.D., D.Sc., D.S.W., or Psy.D, LCPC, and LCSW-C.
        ii. Trained in gender-affirming care and have knowledge about gender diverse identities and expressions as attested by the provider.
    c. The Gender Affirming Care – Medical Necessity Healthcare Provider Certification Form must be included with the request.

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In addition to the above criteria, the following required documentation must be met for all members planning to undergo these specific Gender Affirming Care:

Gender Affirming Medical Treatments:

These include Puberty Suppression, Cross Sex Hormone Therapies, Voice Therapies, and Fertility Preservation (see below for initial authorization):

1. The member has a diagnosis of gender incongruence.
    a. The member's experience of gender incongruence is marked and sustained as attested by the provider.
    b. The provider's attestation stating they have tried to identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender affirming services.
2. The provider has assessed the capacity of the member to consent for treatment prior to initiation.
    a. Adolescent members must demonstrate the emotional and cognitive maturity required to provide informed consent/assent for treatment as attested by the provider.
3. Adolescents must have reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
4. Provider attestation that any mental health and somatic health conditions that could negatively impact the outcome of gender affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
5. Provider attestation that they have assessed the capacity of the member to understand the effect of gender affirming treatment on reproduction and explore reproductive options with the member prior to the initiation of treatment.

Gender Affirming Initial Fertility Preservation:

1. Prior authorization is required and will be authorized for 60 days if the criteria are met.
2. The member is of reproductive age of puberty through menopause.
3. The requesting/treating provider is a Reproductive Endocrinologist.
4. Signed consent is required. When consent involves a minor, parental or guardian consent is required as per MPC policy 8000.33 Consent to Treat Minors.
5. Documentation of Iatrogenic Infertility, including the impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment or intervention affecting reproductive organs or processes.
6. A copy of the treatment plan of the proposed Fertility Preservation Services must be submitted with the request.
7. Additional criteria for the approval of Gonadal Suppression with GNRH Analogs include:
    - GnRH agonists may be offered only to specific breast cancer patients to reduce the risk of premature ovarian insufficiency.
    - Not to be used in place of other fertility preservation alternatives.

8. Additional criteria for approval of Ovarian tissue cryopreservation:
    - Insufficient time for oocyte retrieval or the patient is prepubertal, AND
    - Ovarian tissue is free from malignancy.

Gender Affirming Surgeries:

1. The member has a diagnosis of gender incongruence.
    a. The member's experience of gender incongruence is marked and sustained as attested by the provider.
    b. The provider's attestation statin they have tried to identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender affirming services.
2. The provider has assessed the capacity of the member to consent for treatment prior to initiation.
    a. Adolescent members must demonstrate the emotional and cognitive maturity required to provide informed consent/assent for treatment.
3. Surgeons performing these surgeries must have:
    a. Training and competencies in the assessment of and treatment in gender affirming procedures and surgery as attested by the provider.
    b. Knowledge about gender diverse identities and expressions.
4. Provider attestation that any mental health and somatic health conditions that could negatively impact the outcome of gender affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
5. Provider attestation that they have assessed the capacity of the member to understand the effect of gender affirming treatment on reproduction and explore reproductive options with the member prior to the initiation of treatment.
6. Adult transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals seeking gender affirming genital procedures, including gonadectomy must have **a minimum of 6 months** of gender affirming hormone therapy as appropriate to the person's gender goals before the person undergoes surgical intervention (unless hormone replacement therapy is not clinically indicated, the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity, or is medically contraindicated).
    a. Adolescents must have **a minimum of 12 months** of gender affirming hormone therapy as appropriate to the person's gender goals before the person undergoes surgical intervention (unless hormone replacement therapy is not clinically indicated, the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity, or is medically contraindicated).

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Revision and Reversal Procedures:

1. Documentation from the healthcare professional who has evaluated or has been treating the member, that the proposed revision is medically necessary to address the member's gender incongruence.
2. The surgery or procedure is not for the purpose of reversing the appearance of normal aging.
3. The surgery or procedure is specific to feminization, masculinization, or non-binary transition, and would not be pursued for other reasons such as to improve appearance or correct unrelated medical or surgical problems.

Limitations and Exclusions

Background

The Gender Affirming Care services covered benefits under the MD Medicaid Program include:
Hormone Therapy-
Cross Sex Hormone Therapy- continuous hormone replacement and suppression include hormones:

- Injected by a medical provider in an office setting.
- Oral, transdermal, and injectable hormones covered under the pharmacy benefit.
- Non-FDA approved medications, Over the Counter (OTC), and compounded drugs and medications that do not have an existing billing code are not covered.

Puberty Suppression Therapy includes hormones injected by a medical provider in an outpatient setting.
Gender Affirming Surgeries - When medically necessary the following surgeries are covered:

- Gender Affirming Gender Reassignment Surgeries.
- Gender Affirming Procedures to the Face and Neck.
- Gender Affirming Procedures related to the: Skin, Abdomen, Chest, Trunk, and Buttocks.
- Gender Affirming Procedures related to hair alterations for the purpose of altering secondary sex characteristics and surgical site preparation.
- Gender Affirming Procedures related to Voice, Voic Therapy, and Voice Lessons.

Post Transition Services – gender-specific post transition services may be medically necessary appropriate to their anatomy. Examples include:

- Breast cancer screening for female to male transgender persons who have not undergone a mastectomy.
- Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Reversal & Revision Procedures - These procedures that may be considered medically necessary for transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals include:

- Revisions of previous Gender Affirming Surgeries for complications associated with the original procedure such as infections or impairment of function.

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- Revisions and/or reversals other than for complications that meet medical necessity criteria.

Laboratory Testing may be required for monitoring hormone therapy. Some but not all may require PA.

Behavioral Health Therapy- examples include outpatient psychotherapy/mental health services for gender incongruence and associated comorbid psychiatric diagnoses. These benefits are carved out to the MD BH vendor- Optum Maryland

Fertility Preservation Services –

Covered Services include:

- Fertility Preservation consultation.
- Fertility Preservation Procedures include applicable laboratory assessments, medications, and medically necessary treatments.
- Ovulation induction, monitoring, oocyte retrieval (for the purposes of oocyte retrieval only).
- Oocyte cryopreservation and evaluation.
- Ovarian tissue cryopreservation and evaluation
- Sperm extraction, cryopreservation, and evaluation.
- Gonadal Suppression with GNRH Analogs.

Non-Covered Services and excluded from this policy:

- Donor Sperm.
- Donor Oocytes.
- Fertility Procedures, for example:
  - Intrauterine Insemination
  - In Vitro Fertilization
- Storage and thawing of testicular tissue including associated charges.
- Prepubertal testicular tissue cryopreservation. This is considered investigational.
- Sperm and oocyte banking/storage.
- Thawing of cryopreserved sperm or oocytes.

Codes/Devices/Services

For current codes refer to the MDH Medicaid FFS fee schedule site

https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx

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References

HB 283, Maryland Medical Assistance Program- Gender-Affirming Treatment (Trans Health Equity Act)
§ 15-810.1 of the insurance article

Revision Log

New Policy creation	12/7/2023