Network Notification

Notification Date:	**April 13, 2017**
To:	**Ohio Medicaid, OH Medicare and ALL Marketplace Health Parters**
From:	**CareSource®**
Subject:	**MM-0034, MM-0079, MM-0080 Gender Dysphoria Medical Policy**
Effective Date:	**May 18, 2017**

Effective **May 18, 2017,** CareSource will introduce a new Gender Dysphoria medical policy for Ohio Medicaid, Medicare, and ALL Marketplace plans.

SUMMARY:
The Gender Dysphoria medical policy outlines information consistent with the most up-to-date evidence-based medical literature related to three common gender dysphoria treatment approaches: psychotherapy, hormonal therapy and sexual reassignment surgery. Policy coverage rationale is outlined according to state and federal guidelines.

WHAT YOU NEED TO KNOW:
It is the policy of CareSource to comply with state and federal regulations. There was a longstanding Centers for Medicare and Medicaid Services (CMS) National Coverage Determination (NCD) for transsexual surgery which states transsexual surgery is not covered. However, that determination has been overturned. CareSource treats all members consistent with their gender identity. CareSource does not deny or limit health services that ordinarily or exclusively are available to individuals of one sex to a transgender individual, based on the fact that the individual's sex or gender is different from the one to which health services are normally or exclusively available.

Medical necessity:
- CareSource covers those services that are medically necessary.
- In determining services that are medically necessary, or the coverage of health services related to gender transition, CareSource utilizes neutral standards supported by evidence-based criteria.
- Members under the age of 21 will be reviewed for medical necessity as required by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Surgery, including breast/chest surgery and genital surgery will be reviewed for medical necessity on a case-by-case basis according to the criteria outlined in this policy.

Prior authorization:
- Prior authorization must be submitted for genital or breast surgery involved with the gradual progression from male to female or female to male.
- The prior authorization is only valid if the member is eligible for the applicable item or service on the date of service.
- Behavioral health evaluation is required and must be submitted as part of the prior authorization request for surgery.

Covered benefits
- Behavioral health services for children, adolescents and adults are covered according to the criteria outlined in this policy.
- Hormone therapy is covered for male to female (MtF) members 18 and over and when medically necessary as outlined in this policy.
- At the time of this policy, the local Medicare Administrative Contractors (MAC) serving Ohio have not issued a local coverage determination (LCD).
- Procedures or surgeries to enhance secondary sex characteristics are considered cosmetic and are **not medically necessary**. A non-exhaustive list of procedures and surgeries

considered cosmetic are outlined in this policy.

You may refer to the specific policy for more information on policy criteria and rationale, any applicable CPT and ICD-10 codes, and conditions of coverage.

NEXT STEPS:
The full policy is effective on **May 18, 2017** and may be found on the CareSource.com Health Partner Policies web page. To access the policy, navigate to the Medical Policies section of the page, click on the appropriate Plan Name and State, then reference the Gender Dysphoria medical policy. You may also access the policies directly at the links below:

- Ohio Medicaid Gender Dysphoria Medical Policy
- Ohio Medicare Gender Dysphoria Medical Policy
- All Marketplace Plans Gender Medical Dysphoria Policy

Thank you in advance for your cooperation in adhering to this policy requirement.

For the most up to date notifications from CareSource, visit the Updates and Announcements page on **CareSource.com**.

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