



MedStar Family Choice

ADMINISTRATIVE POLICY AND PROCEDURE

Policy #:	1415	
Subject:	Gender Affirming Care	
Section:	Medical Non-Pharmacy Protocols	
Initial Effective Date:	02/01/2016	
Revision Effective Date(s):	07/18, 07/19, 07/20, 07/21, 08/21, 10/21, 07/22, 08/22, 11/22, 07/23, 01/24, 2/24, 07/24, 8/24, 7/25, 7/26	
Historical Revision Date(s):	07/17	
Review Effective Date(s):		
Historical Review Date(s):	10/16	
Responsible Parties:	Medical Director	
Responsible Department(s):	Clinical Operations	
Regulatory References:	Maryland Department of Health (MDH) PT 52-24 MCO Transmittal No. 198, January 4, 2024	
Approved:	AVP Clinical Operations	Chief Medical Officer

Purpose: To define the conditions under which MedStar Family Choice (MFC) will approve Gender Affirming Treatment.

Scope: MedStar Family Choice, Maryland

Policy: It is the policy of MedStar Family Choice (MFC) to authorize medically necessary gender affirming treatment as outlined in the criteria below. This guideline is in accordance with Maryland Department of Health (MDH) PT 52-24 MCO Transmittal No. 198, January 4, 2024, and MDH Gender-Affirming Treatment Services Under the Maryland Medicaid Program, Effective January 1, 2024

Background:

MedStar Family Choice (MFC) will follow the criteria outlined by The Maryland Department of Health (MDH). This is in accordance with the Maryland Medical Assistance Program-Gender-Affirming Treatment (Trans Health Equity Act). MedStar Family Choice (MFC) will provide medically necessary gender-affirming treatment in a nondiscriminatory manner. These services

will be assessed according to nondiscriminatory criteria that are consistent with current clinical standards of care.

Services available through MedStar Family Choice (MFC) include medications and surgical procedures. Psychotherapy/mental health services are an important component of the overall care of gender incongruence. In Maryland, most mental health services are provided through the behavioral health administrative services organization (BHASO). MedStar Family Choice (MFC) is responsible for psychological testing that is required prior to gender affirming procedures.

MedStar Family Choice (MFC) will encourage all members to obtain care for Gender Dysphoria at a place of service with expertise in the care of this condition.

Definition:

Gender-affirming treatment means any medically necessary treatment that is consistent with current standards of care prescribed by a licensed health care provider for treating a condition related to an individual's gender identity.

Procedure:

1. Requests for medical or surgical benefits should be submitted with appropriate medical and psychiatric records as well as letters of medical necessity as indicated by the policies outlined below.

Covered Benefits:

(Prior Authorization May Be Required)

1. Hormone Therapy
 - a. Cross Sex Hormone Therapy
 - i. Continuous hormone replacement and suppression therapy which includes hormones injected by a medical provider in an office setting as well as oral, transdermal, and injectable hormones covered under the pharmacy benefit.
 - b. Puberty Suppression Therapy
 - i. Includes hormones injected by a medical provider in an outpatient setting.
 - c. NOT Included (not covered by Maryland Medicaid/MedStar Family Choice)
 - i. Non-FDA approved medications.
 - ii. Compounded drugs/ medications.
2. Gender Affirming Surgeries When Medically Necessary
 - a. Gender Affirming Gender Reassignment Surgeries
 - b. Gender Affirming Procedures to the Neck and Face
 - c. Gender Affirming Procedures related to the Abdomen, Chest, Trunk, Buttocks, and Skin

- d. Gender Affirming Procedures related to hair alterations, to alter secondary sex characteristics, and surgical site preparation.
 - e. Gender Affirming Procedures related to Voice, Voice Therapy, and Voice Lessons
 - f. Laser treatment for scars that are a result of gender affirming surgery
3. Post Transition Services
- a. Gender specific post transition services may be medically necessary for transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals appropriate for their anatomy. For example, breast cancer screening maybe medically necessary for female to male transgender persons who have not undergone mastectomy. Another example is prostate cancer screening for male to female transgender individuals that have retained their prostate.
4. Revision and Reversal Procedures
- a. Revisions of previous Gender Affirming Surgeries for complications associated with the original procedure (infections or impairment of function) may be considered medically necessary.
 - b. Revisions and/or reversals of previous Gender Affirming Surgeries other than for complications, that meet medical necessity criteria.
 - i. The following are the medical necessity criteria that apply to Revision and Reversal Procedures
 - 1. There must be documentation from the healthcare professional that has been treating or who has evaluated the patient, that the revision is medically necessary to address the patient's gender incongruence.
 - 2. The surgery/procedure is not for the purpose of reversing the appearance of normal aging.
 - 3. The surgery/procedure is specific to masculinization, feminization, or non-binary transition and would not be done for other reasons, e.g., to improve appearance or to correct medical or surgical problems unrelated to masculinization, feminization, or non-binary transition.
5. Laboratory Testing
- a. Lab testing required for the monitoring of hormone therapy. The benefits are the same as any other outpatient diagnostic service.
6. Behavioral Health Therapy
- a. Behavioral health services may be medically necessary for transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals.
 - b. Benefits are the same as any other mental health service. Most mental health services are provided through the behavioral health administrative services organization (BHASO). MedStar Family Choice (MFC) is responsible for psychological testing that is required prior to gender affirming procedures.

7. Fertility Preservation Services (see MedStar Family Choice (MFC) Policy #1433 - Fertility Preservation Services)
 - a. Fertility Preservation Services are those procedures that are considered medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is the impairment of fertility by surgery, radiation, chemotherapy, or other medical interventions/treatments affecting the reproductive organs or processes.
 - b. Fertility Preservation Services are different from infertility services.
8. Gender affirming medical tattooing benefit include all medically necessary tattooing, including but no longer limited to breast tattooing.

Required Documentation for Gender Affirming Care:

Requirements for Gender Affirming Medical Treatments

(Puberty Suppression, Cross Sex Hormone Therapies, Voice Therapies, Fertility Preservation)

- The member must have a diagnosis of gender dysphoria.
 - The member's experience of gender incongruence is significant and sustained.
 - Practitioner attestation that the practitioner has tried to identify and exclude other possible causes of apparent gender incongruence prior to starting gender affirming treatments.
- Practitioner has assessed the capacity of the member to consent for treatment prior to beginning gender affirming treatments.
 - Member must demonstrate capacity to make informed decisions and consent to treatments.
 - If the member is a minor, parental consent will be required.
 - Current Maryland Minor Consent Laws will be used to determine who can consent for what services and practitioner's obligations #
 - Adolescent members must demonstrate emotional and cognitive maturity necessary to provide informed consent/assent.
 - Practitioners must collect and maintain proof of parental authorization. This must be available to send to MedStar Family Choice (MFC) upon request.
- Letter of Assessment of the medical necessity for the requested medical treatment(s)
 - For Adults: One letter of assessment from either a Mental Healthcare Professional (MHP)** or a Somatic Healthcare Professional (SHP)* /Primary Care Provider (as defined in COMAR 10.67.05.05A(5))§ who has competencies in the assessment of transgender/gender diverse people.
 - For Adolescents: At least one letter of assessment from a multidisciplinary team that includes both somatic and mental health professionals is required. The letter will be accepted from either the SHP or the MHP member of the team. This letter must reflect the assessment and opinion of the team.

- Practitioner attestation that any mental health and/or somatic health conditions that could negatively impact gender-affirming medical treatments have been assessed and the risks and benefits have been discussed prior to making a decision regarding treatment.
- Practitioner attestation that they have assessed the capacity of the member to understand the effect of gender-affirming treatment on reproduction and have discussed reproductive options with the member prior to beginning gender affirming treatment.
- Adolescents must have reached Tanner Stage 2 of puberty before pubertal suppression can be started.

Requirements for Gender Affirming Surgeries

- The member must have a diagnosis of gender dysphoria.
 - The member's experience of gender incongruence is significant and sustained
 - Practitioner attestation that the provider has tried to identify and exclude other possible causes of apparent gender incongruence prior to starting gender affirming surgeries.
- Practitioner has assessed the capacity of the member to consent for treatment prior to beginning gender affirming treatments.
 - Member must demonstrate capacity to make informed decisions and consent to treatments.
 - If the member is a minor, parental consent will be required.
 - Current Maryland Minor Consent Laws will be used to determine who can consent for what services and practitioner's obligations #
 - Adolescent members must demonstrate emotional and cognitive maturity necessary to provide informed consent/assent.
 - Practitioners must collect and maintain proof of parental authorization. This must be sent to MFC with the Prior Authorization request.
- Letter of Assessment of the medical necessity for the requested surgical treatment(s)
 - For Adults: One letter of assessment from either a Mental Healthcare Professional (MHP)** or a Somatic Healthcare Professional (SHP)* /Primary Care Provider (as defined in COMAR 10.67.05.05A(5))*** who has competencies in the assessment of transgender/gender diverse people.
 - For Adolescents: At least one letter of assessment from a multidisciplinary team that includes both somatic and mental health professionals is required. The letter will be accepted from either the SHP or the MHP member of the team. This letter must reflect the assessment and opinion of the team.

- Practitioner attestation that any mental health and/or somatic health conditions that could negatively impact gender-affirming medical treatments have been assessed and the risks and benefits have been discussed prior to making a decision regarding treatment.
- Practitioner attestation that they have assessed the capacity of the member to understand the effect of gender-affirming treatment on reproduction and have discussed reproductive options with the member prior to beginning gender affirming treatment.
- Surgeons performing gender affirming surgeries must have the following:
 - Training and documented supervision in gender affirming procedures.
 - Maintenance of an active practice in gender-affirming surgical procedures
 - Knowledge about gender diverse identities and expressions
 - Continuing education in gender affirmation surgery
 - Tracking of surgical outcomes
- Adult transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals seeking gender affirming genital procedures, including gonadectomy, must have had at least six (6) months of gender affirming hormone therapy as appropriate to their gender goals prior to surgical procedures. Exceptions to this criterion are made when the use of hormone therapy is not clinically indicated, is medically contraindicated, or is inconsistent with the member's desires, goals, or expressions of gender identity.
 - Adolescents must have at least twelve (12) months of gender affirming hormone therapy as appropriate to their gender goals prior to gender affirming surgical procedures. Exceptions to this criterion are made when the use of hormone therapy or gonadal suppression is not clinically indicated, is medically contraindicated, or is inconsistent with the member's desires, goals, or expressions of gender identity.

Covered CPT Codes

- Transition Surgeries
- Procedures to the Face and Neck
- Procedures Related to the Skin, Abdomen, Chest, Trunk, Buttocks
- Alterations to Voice, Voice Therapy, and Voice Lessons
- Revision and Reversal Procedures
- Laboratory Service Codes
- Hormone Therapy Codes
- Puberty Suppression Medications
- Fertility Preservation Codes

[Gender Affirming Treatment Codes](#)

*SHP (Somatic Healthcare Professionals) must meet all of the following criteria:

- Must be a somatic primary care healthcare professional with one of the following degrees: MD, DO, Ph.D., PA or NP
- Trained in gender affirming treatment and understands gender diverse identities and expressions.
- Demonstrates continuing education in gender affirming healthcare.

**MHP (Mental Health Professionals) must meet all the following criteria:

- Must be a mental health professional with one of the following degrees: Ph.D., MD, DO, Ed.D, D.SC., D.S.W., Psy.D, LCPC, or LCSW-C
- Trained in gender affirming care and understands gender diverse identities and expressions.
- Demonstrates continuing education in gender affirmation and mental healthcare.

COMAR 10.67.05.05A(5)

A. Primary Care Provider (PCP)

(5) An MCO may include, as appropriate, any of the following practitioners to serve as the primary care provider for an enrollee:

(a) General practitioner.

(b) Family practitioner.

(c) Internist.

(d) Pediatrician.

(e) OB/GYN.

(f) Physician assistant.

(g) Certified nurse midwife.

(h) Nurse practitioner certified in any of the following areas of specialization:

(i) Adult.

(ii) Pediatric.

(iii) Geriatric.

(iv) OB/GYN.

(v) School nurse; or

(vi) Family; and

(i) A physician practicing in a specialty area other than those enumerated in §A(5)(b)—(e) of this regulation.

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Treatment of
Minors.pdf

References

Maryland Department of Health (MDH) MCO Transmittal No. 198, January 4, 2024
Updated Guidance – Expanded Medicaid Coverage of Gender-Affirming Treatments

Maryland Medical Assistance Program MCO Transmittal No. 224, October 3, 2024;
Expanded Coverage for Gender Affirming Medical Services

Summary of Changes:	07/26 • Added language gender affirming tattooing expanded to all medical necessary gender affirming medical tattooing and not just limited to breast tattooing. • Added Reference Transmittal No 224 07/25 • Added link for covered CPT codes for surgeries, procedures, and medications 08/24: • Removed old transmittal reference from “Background” section and replaced with general terms referencing Maryland law • Removed specific names for “Responsible Parties” and “Approved”; just using titles. 07/24: • Removed specific names for “Responsible Parties” and “Approved”; just using titles • Added PT 52-24 to MCO Transmittal No. 198
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	02/24: • Changed regulatory reference to MDH MCO Transmittal No. 198 • Clarified laser treatment of scars from gender affirming surgery is covered • Clarified somatic health professional as somatic primary care healthcare professional 01/24: • changed policy title to Gender Affirming Care • wrote entirely different policy based on MDH MCO Transmittal No. 193 07/23: • Updated approved by to Carol Attia and Dr. Wills • Changed policy title. 11/22: • Removed 19324 as code retired from use; replaced with 15771, 15772. 08/22: • Under Male to Female Transition added codes for vaginoplasty using colon or small intestine. 07/22: • Added services to reverse gender reassignment procedures not covered. • Removed Dr. Toye's name from responsible parties. • Formatted reference section. 10/21: • Added new CPTs 56625 (vulvectomy; simple, complete), 15860 (inject agent to test vascular flow in graft/flap) and 15241 (full thickness graft, each additional 20sq cm) to Table 1. • CPTs 15750 and 15240 were added to Male to Female Transition (Table 1); they were already in Female to Male Transition (Table 1). 08/21: • Updated Table 1, Section Male to Female Transition: Addition of CPT 54125 (Penectomy; complete) and CPT 45395 (Colovaginoplasty; laparoscopic). • Added asterisk to Table 1. 07/21: • Updated Responsible Departments from Utilization Management to Clinical Operations. • Added "Maryland" to scope. 07/20:
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	• Table 1, Section Female to Male: Removal of CPT 19304 mastectomy subcutaneous because code retired from use. 07/19: • Removal of “A” from policy number. • Removal of “Maryland” from scope. • Updated Table 1: Listing of Covered Services (Assuming All Criteria Are Met). 07/18: • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. 07/17: • Changed Carol Attia to Theresa Bittle and updated Dr. Patryce Toye’s title from Senior Medical Director to Chief Medical Officer. • Added MFC. • Changed Physician Advisor to Medical Director. • Changed DHMH to MDH. 10/16: • No changes. 02/16: • New policy.
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