



PROVIDER POLICIES & PROCEDURES

GENDER AFFIRMATION SURGERY

The primary purpose of this policy is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for gender affirmation surgery. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Gender affirmation surgery is one option in the treatment of severe cases of gender dysphoria, a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with an intense sense of discomfort with their own gender. Gender affirmation surgery is not a single procedure, but part of a complex process involving multiple medical, psychiatric and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes. Before undergoing gender affirmation surgery, important medical and psychological evaluations, medical therapies and behavioral trials should be undertaken and completed to confirm that surgery is the most appropriate treatment choice for the individual.

CLINICAL GUIDELINE

Coverage guidelines for gender affirmation surgery are made in accordance with the CT Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows;

Mastectomy and creation of a male chest may be considered medically necessary as part of female to male gender affirmation when all of the following criteria are met:

1. The individual has capacity to make fully informed decisions and consent for treatment; and
2. The individual has been diagnosed with gender dysphoria, and exhibits all of the following:
 - a. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
 - b. The transsexual identity has been present persistently for at least two years; and
 - c. The disorder is not a symptom of another mental disorder; and
 - d. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
3. If the individual has significant, outstanding medical or mental health conditions present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic

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medications and/or psychotherapy before surgery is contemplated

4. One referral from a qualified mental health professional who has assessed the individual.

NOTE:

Chest surgery in adolescents in female to male gender affirmation could be carried out, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Breast Augmentation may be considered medically necessary as part of male to female gender affirmation when breast enlargement, after undergoing hormone treatment for 24 months, is not sufficient for comfort in the social gender role and when all of the following criteria are met:

1. The individual has capacity to make fully informed decisions and consent for treatment; and
2. The individual has been diagnosed with gender dysphoria, and exhibits all of the following:
 - a. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
 - b. The transsexual identity has been present persistently for at least two years; and
 - c. The disorder is not a symptom of another mental disorder; and
 - d. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
3. If the individual has significant, outstanding medical or mental health conditions present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated
4. One referral from a qualified mental health professional who has performed a person-centered assessment of the individual.

For individuals undergoing gender affirmation surgery, consisting of any combination of the following: hysterectomy, salpingo-oophorectomy; ovariectomy, vasectomy or orchiectomy, the procedures may be considered medically necessary when all of the following criteria are met:

1. The individual has capacity to make fully informed decisions and consent for treatment; and
2. The individual has been diagnosed with gender dysphoria, and exhibits all of the following:
 - a. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
 - b. The transsexual identity has been present persistently for at least two years; and
 - c. The disorder is not a symptom of another mental disorder; and
 - d. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
3. Unless there is a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and
4. If the individual has significant, outstanding medical or mental health conditions present, they must be

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reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

5. **Two** referrals from qualified mental health professionals ** who have performed a person-centered independent assessment of the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required; and
6. One referral from a medical professional (MD, DO, or Advanced Practice Registered Nurse [APRN]).

NOTE:

Genital surgery is typically not carried out in adolescents until the adolescent has the capacity to make fully informed decisions and consent to treatment.

For individuals undergoing gender affirmation surgery, consisting of any combination of the following: metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses, the procedures may be considered medically necessary when all of the following criteria are met:

1. The individual has capacity to make fully informed decisions and consent for treatment; and
2. The individual has been diagnosed with gender dysphoria and exhibits all of the following:
 - a. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
 - b. The transsexual identity has been present persistently for at least two years; and
 - c. The disorder is not a symptom of another mental disorder; and
 - d. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
3. Unless there is a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and
4. Documentation that the individual has completed a minimum of 12 months of successful continuous full time real-life experiences in their new gender, across a wide range of life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences).

Note:

- The medical documentation should include the start date of living full time in the new gender.
 - Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases; and
5. Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; and
 6. If the individual has significant, outstanding medical or mental health conditions present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with

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- psychotropic medications and/or psychotherapy before surgery is contemplated; and
7. **Two** referrals from qualified mental health professionals ** who have performed a person-centered independent assessment of the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required; and
 8. One referral from a medical professional (MD, DO, or Advanced Practice Registered Nurse [APRN]).

**At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D.) or a master's level degree in a clinical behavioral science field (for example, M.S.W., L.C.S.W., Nurse Practitioner [N.P.], Advanced Practice Nurse [A.P.R.N.], Licensed Professional Counselor [L.P.C.], and Marriage and Family Therapist [M.F.T.]) and be capable of adequately evaluating comorbid psychiatric conditions. One letter may be sufficient if signed by two providers, one of whom has met the specifications set forth above.

NOTE:

Genital surgery is typically not carried out in adolescents until the adolescent has the capacity to make fully informed decisions and consent to treatment.

Facial feminization procedures (e.g. rhinoplasty, facial bone reconstruction, blepharoplasty, etc., and electrolysis) may be considered medically necessary as part of male to female gender affirmation when all of the following criteria are met:

1. The individual has capacity to make fully informed decisions and consent for treatment; and
2. The individual has been diagnosed with gender dysphoria, and exhibits all of the following:
 - a. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
 - b. The transsexual identity has been present persistently for at least two years; and
 - c. The disorder is not a symptom of another mental disorder; and
 - d. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
3. If the individual has significant, outstanding medical or mental health conditions present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and
4. Unless there is a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professionals and provider under the supervision of a physician; and
5. A letter from a qualified mental health professional certifying that the individual is experiencing significant psychosocial distress due to perceived inability to pass in the community as a member of the self-identified gender, letter should be specific to the individual's unique experiences; and
6. Facial photographs (both front and side views) for facial procedures, or of the affected part of the body.

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Surgical Revision

Surgery to refine the results of a previous surgical procedure, including breast augmentation, mastectomy, facial feminization and genital reconstruction may be considered medically necessary if the surgery is needed to address a functional impairment resulting from the previous surgery. If not reconstructive in nature, the procedure will be considered cosmetic and therefore not medically necessary.

Documentation from the medical/surgical provider describing the impairment is required.

Cosmetic Procedures for Aging Skin

Procedures to address aging skin (e.g. loose skin on cheeks and jawline, wrinkles [brow furrows, frown lines, crow's feet, laugh lines etc.], eye bags, sun damage, age spots, drooping eyelids, thinning/creases/wrinkles of skin of face/chest) are not reconstructive in nature and are therefore typically considered *cosmetic* and *not* medically necessary. These procedures include but are not limited to:

- Chemical peels
- Dermabrasion,
- Laser resurfacing
- Use of radio waves
- Intense pulsed light technology
- Botulinum toxin
- Cosmetic fillers (including collagen, hyaluronic acid injections, fat transplantation and implants)
- Facelift or other skin tightening procedures
- Brow lift
- Eyelid procedures

Use of Hormone Therapy in Adolescents:

Puberty Suppressing Hormone Therapy:

Puberty-suppressing hormones may be appropriate in adolescents as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. The use of puberty – suppressing hormones:

- May give adolescents more time to explore their gender nonconformity and other developmental issues; and
- May facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue gender affirmation surgery.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen.

Feminizing/Masculinizing Hormone Therapy

Feminizing/masculinizing hormone therapy may be appropriate, Ideal treatment would be after evaluation by, or under the supervision of, a clinician with knowledge in bone development, e.g. pediatrician or pediatric endocrinologist. Treatment decisions should involve the adolescent, the family, and the treatment team.

EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that

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requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization of gender affirmation surgery is required. Requests for coverage will be reviewed in accordance with the processes in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for gender affirmation surgery:

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal; and
2. Documentation from the referring provider which supports the medical necessity of the requested procedure(s) and which includes all documentation and referrals outlined in the above criteria.

EFFECTIVE DATE

This Policy is effective for prior authorization requests for gender affirmation surgery for individuals covered under the HUSKY Health Program beginning April 2, 2015.

LIMITATIONS

At this time, gender affirmation surgery is not a covered benefit under the HUSKY B program.

DEFINITIONS

1. **HUSKY A:** Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B:** Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C:** Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D:** Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program:** The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP:** Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity:** (as defined in Connecticut General Statutes § 17b-

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259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization:** A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

Peer Reviewed Publications:

1. Bradley SJ, Zucker KJ. Gender identity disorder: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry.* 1997; 36(7):872-880.
2. Cohen-Kettenis PT, Gooren LJ. Transsexualism: a review of etiology, diagnosis and treatment. *J Psychosom Res.* 1999; 46(4):315-333.
3. Eldh J, Berg A, Gustafsson M. Long-term follow up after sex reassignment surgery. *Scand J Plast Reconstr Surg Hand Surg.* 1997; 31(1):39-45.
4. Hepp U, Kraemer B, Schnyder U, et al. Psychiatric comorbidity in gender identity disorder. *J Psychosom Res.* 2005; 58(3):259-261.
5. Landen M, Walinder J, Lambert G, Lundstrom B. Factors predictive of regret in sex reassignment. *Acta Psychiatr Scand.* 1998; 7(4):284-289.
6. Mate-Kole C, Freschi M, Robin A. A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals. *Br J Psychiatry.* 1990; 157:261-264.
7. Midence K, Hargreaves I. Psychosocial adjustment in male-to-female transsexuals: an overview of the research evidence. *J Psychol.* 1997; 131(6):602-614.
8. Monstrey S, Hoebeke P, Dhont M, et al. Surgical therapy in transsexual patients: a multi-disciplinary approach. *Acta Chir Belg.* 2001; 101(5):200-209.
9. Parkes G, Hall I. Gender dysphoria and cross-dressing in people with intellectual disability: a literature review. *Ment Retard.* 2006; 44(4):260-271.
10. Schlatterer K, von Werder K, Stalla GK. Multistep treatment concept of transsexual patients. *Exp Clin Endocrinol Diabetes.* 1996; 104(6):413-419.
11. Selvaggi G, Ceulemans P, De Cuyper G, et al. Gender identity disorder: general overview and surgical treatment for vaginoplasty in male-to-female transsexuals. *Plast Reconstr Surg.* 2005; 116(6):135e-145e.
12. Smith YL, Van Goozen SH, Kuiper AJ, Cohen-Kettenis PT. Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychol Med.* 2005; 35(1):89-99.

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Government Agency, Medical Society, and Other Authoritative Publications:

1. American Medical Association, Current Procedural Terminology Manual: 2018
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. 2013. Washington, DC. Pages 451-459.
3. Centers for Medicare and Medicaid Services. National Coverage Determination: Transsexual Surgery. NCD #140.3. Effective date not available. Available at: http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd. Accessed on May 29, 2013.
4. Day P. Trans-gender reassignment surgery. New Zealand health technology assessment (NZHTA). The clearing house for health outcomes and Health technology assessment. February 2002; Volume 1 Number 1. Available at: <http://www.otago.ac.nz/christchurch/otago014010.pdf> Accessed on May 29, 2013.
5. World Professional Association for Transgender Health (WPATH). Standards of care for the health of transsexual, transgender, and gender nonconforming people. 7th version. 2011. Available at: http://www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf Accessed on May 29, 2013.
6. World Professional Association for Transgender Health (WPATH) (formerly The Harry Benjamin International Gender Dysphoria Association). Standards of Care for Gender Identity Disorders. 6th version. 2001 Feb. Available at: <http://www.medical-tourism-in-thailand.com/harry-benjamin-international-gender-dysphoria-association-standards-of-care-for-gender-identity-disorders.pdf> Accessed on May 29, 2013.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	April 2, 2015	Approved by DSS on April 2, 2015.
Reviewed	June 2015	Clinical Quality Subcommittee Review. Clarified language in Clinical Guideline section concerning need for hormone therapy. Updated reference for AMA CPT Manual to most current version.
Updated	March 2016	<p>Updates to language in introductory paragraph pertaining to purpose of policy.</p> <p>Updates to Clinical Guideline section pertaining to definition of Medical Necessity.</p> <p>Updates throughout policy to reflect importance of person-centeredness when reviewing requests for these procedures.</p> <p>Added the following criteria:</p> <ul style="list-style-type: none"> • Mastectomy/creation of male chest as part of male to female reassignment • Breast augmentation as part of male to female reassignment • Genital hair removal as part of male to female Reassignment • Use of hormone therapy in adolescents <p>Updated section related to additional procedures related to gender reassignment. Removed code list. Changes approved by Clinical Quality Subcommittee on March 21, 2016. Changes approved by</p>

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		DSS on April 22, 2016.
Updated	Nov 2016	Update to further define the necessary qualifications of mental health professionals submitting referrals for gender reassignment surgery. Change approved at the November 9, 2016 CHNCT Medical Policy Committee meeting. Change approved at the December 20, 2017 CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on January 3, 2017.
Updated	April 2017	Added criteria for facial feminization procedures. Removed list of procedures that require case-by-case review. Changes approved by DSS on March 31, 2017. Changes approved by CHNCT Medical Policy Review Committee on April 26, 2017. Changes approved by Clinical Quality Subcommittee on June 19, 2017.
Updated	April 2018	Medical Policy Committee review. Reference update. Approved by CHNCT Medical Policy Review Committee on February 14, 2018. Approved by CHNCT Clinical Quality Subcommittee on March 19, 2018. Approved by DSS on April 5, 2018.
Updated	July 2018	Update to change gender reassignment surgery to gender affirmation surgery. Change approved by DSS on July 17, 2018.
Updated	November 2018	Update to Clinical Guideline section that referrals should be based on person-centered assessment of individual. Update to Clinical Guideline section under Facial Feminization to include statement that letter from qualified mental health professional “should be specific to the individual’s unique experiences.” Formatting changes – moved language regarding letter/referral requirements/qualifications of mental health professional. Change approved at the November 14, 2018 CHNCT Medical Policy Review Committee meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 17, 2018. Approved by DSS on January 28, 2019.
Updated	February 2019	Added Surgical Revision to Clinical Guideline section: <i>Surgical Revision</i> <i>Surgery to refine the results of a previous surgical procedure, including breast augmentation, mastectomy, facial feminization and genital reconstruction may be considered medically necessary if the surgery is needed to address a functional impairment resulting from the previous surgery.</i> <i>Documentation from the medical/surgical provider describing the impairment is required.</i> Change approved at the February 27, 2019 Medical Reviewer Meeting.

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		<ul style="list-style-type: none"> • Added need for hormone therapy prior to facial feminization procedures to the Clinical Guideline section. • Added section on procedures to address aging skin to the Clinical Guideline section. <p>Changes approved at the March 13, 2019 Medical Reviewer Meeting.</p> <p>Changes approved by the CHNCT Clinical Quality Subcommittee on March 18, 2019.</p> <p>Approved by DSS on March 27, 2019.</p>
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