



Utilization Review Guideline: Gender-Affirming Services

Read First

IMPORTANT INFORMATION CONCERNING WELLFLEET UTILIZATION REVIEW GUIDELINES

This Utilization Review Guideline serves as notice to health care members and providers of Wellfleet's Prior Authorization practices. Health providers and members are advised to consult the member's specific benefit coverage document for determining specific Plan benefits and coverage.

Wellfleet may use reasonable discretion in applying these Utilization Review Guidelines to health care services provided to its enrollees. This Utilization Review Guideline does not address all the issues related to coverage and medical necessity for health care services. Other factors impacting reimbursement may supplement, modify or, in some cases, supersede this Utilization Review Guideline. These factors may include, but are not limited to, legislative mandates, the type of provider arrangement and the terms of that agreement, and/or the member's benefit coverage document.

Wellfleet may modify this Utilization Review Guideline at any time to comply with changes in national standards, changes in best practices, or other factors that may impact this Utilization Review Guideline. Should this Utilization Review Guideline be revised, Wellfleet shall publish a new version of this Utilization Review Guideline. Wellfleet encourages members and providers to keep current with any CPT or HCPCS updates as well as industry standards related to the services described in this Utilization Review Guideline.

Providers are responsible for submission of accurate claims. Wellfleet reserves the right to request supporting documentation for claims submitted, including provider records.

UTILIZATION REVIEW GUIDELINE
Guideline No: UR-001
**Applicable
Plans**

- Student Health Insurance (for policies issued or renewing after May 2019)
 - Fully Insured
 - Excluding policies issued in the following states: N/A
 - Excluding Wellfleet Global
 - Self-Funded
 - Excluding policies issued by the following schools:
Johns Hopkins University

Purpose

The purpose of this document is to clarify what Wellfleet offers regarding transition-related covered benefits. Wellfleet has grouped these services relating to their Prior Authorization requirements, if any, and coverage under Wellfleet’s benefit plan.

Scope

- All transition-related requests for services for all gender diverse members
- If any service with a given request falls under a conflicting State regulation, the State regulation would override this guideline for that service

Definitions

- Cisgender: refers to people whose current gender identity corresponds to the sex they were assigned at birth
- Gender-Affirmation Surgery (GAS): is used to describe surgery to change primary and/or secondary sex characteristics to affirm a person’s gender identity
- Gender Diverse: is a term used to describe people with gender identities and/or expressions that are different from social and cultural expectations attributed to their sex assigned at birth. This may include, among many other culturally diverse identities, people who identify as nonbinary, gender expansive, gender nonconforming, and others who do not identify as cisgender.
- Gender Dysphoria: describes a state of distress or discomfort that may be experienced because a person’s gender identity differs from that which is physically and/or socially attributed to their sex assigned at birth. Not all transgender and gender diverse people experience gender dysphoria.

- Nonbinary: refers to those with gender identities outside the gender binary of the two identified genders of men and women
 - Sex Assigned At Birth: refers to a person's status as male, female, or intersex based on physical characteristics
 - Transgender: or trans are umbrella terms used to describe people whose gender identities and/or gender expressions are not what is typically expected for the sex to which they were assigned at birth
 - Transgender Men: are people who have gender identities as men and who were assigned female at birth. They may or may not have undergone any transition.
 - Transgender Women: are people who have gender identities as women and who were assigned male at birth. They may or may not have undergone any transition.
 - Transition: refers to the process whereby people usually change from the gender expression associated with their assigned sex at birth to another gender expression that better matches their gender identity. People may transition socially by using methods such as changing their name, pronoun, clothing, hair styles, and/or the ways that they move and speak. Transitioning may or may not involve hormones and/or surgeries to alter the physical body.
-

Guidelines

1. Coverage for gender-affirming services varies across plans.
 - Refer to the customer's benefit plan document for coverage details.
 - Coverage for gender-affirming services, including gender reassignment surgery and related services may be governed by state and/or federal mandates.
 - Coverage of drugs for hormonal therapy, as well as whether the drug is covered as a medical or a pharmacy benefit, varies across plans.
2. There are two gender-affirming services options available for each Wellfleet Plan as described below.
3. Medically necessary services listed under Option 1 are the standard gender-affirming covered benefits under a Wellfleet benefit Plan (unless either otherwise specified in the benefit plan or State regulations require otherwise).
4. Schools/groups have the option of requesting to add the additional gender-affirming services listed under Option 2 to their Wellfleet benefit plan.
 - Options 2 is available at the time of policy renewal.
 - You may contact your Account Executive or Account Manager for details.

5. Option 1: standard gender-affirming covered benefits under a Wellfleet benefit Plan. Includes both non-precertified and precertified services below:
 - Non-procedural outpatient services: no precertification required.
 - Includes medical and behavioral health outpatient office visits, hormonal treatments, laboratory testing, speech therapy, and age-related, gender-specific services, including preventive health, as appropriate to the individual's biological anatomy
 - Includes tracheal shave (chondrolaryngoplasty)
 - Gender-affirming surgeries and procedures: precertification required.
 - This includes top & bottom surgeries, including associated supportive procedures.
 - See Attachments 1 and 2 for associated Prior Authorization requirements
6. Option 2: available additional gender-affirming services.
 - Facial feminization surgeries (FFS): precertification required.
 - See Attachments 1 and 2 for associated Prior Authorization requirements
7. Note: Please note, there are certain code-dependent services that fall under each Option, which will require special review and precertification.
 - This includes procedures with unlisted/unspecified/other codes, custom preparation prostheses, investigational procedures, etc.
 - These are generally not covered a benefit under any Wellfleet Plan. However, Wellfleet understands that due to the nature of gender-affirming services, providers occasionally need to use these codes/services for gender-affirming procedures.
 - Wellfleet will review any of these codes under their appropriate Options, and according to their respective Payment Guideline requirements, if that Option has been chosen by your Plan.
 - See Attachments 1 and 2 for associated Prior Authorization requirements.

Attachments

1. Prior Authorization Requirements for Gender Affirming Procedures
 2. Prior Authorization Requirements for Gender Affirming Procedures for California Plan
-

UTILIZATION REVIEW GUIDELINE

**Related
Resources**

1. WPATH SOC 8
2. Wellfleet Unlisted Codes Payment Guideline
 - 1) <https://wellfleetstudent.com/providers/>
3. Wellfleet Investigational & Experimental Payment Guideline
 - 1) <https://wellfleetstudent.com/providers/>
4. Gender Affirming Services Administrative Guideline UR-005

**Change
History**

Version	Effective Date	Next Review Date
1.0	10/01/2020	7/01/2021
2.0	5/25/21	6/25/21
3.0	12/1/21	12/1/22
3.1	2/8/22	12/1/22
4.1 ¹	3/1/23	1/1/24
4.2	7/21/23	1/1/24

¹ Title change from “Transgender Services” to “Gender-Affirming Services”

**Attachment 1: Prior Authorization Requirements for Gender-Affirming Services: All States
Except California**

- **Option 1:** Includes both non-precertified and precertified services below:
 - Non-procedural outpatient services and tracheal shave: no precertification required.
 - Includes the following:
 - Behavioral health services, including but not limited to counseling for gender incongruence and related psychiatric conditions (e.g., anxiety, depression)
 - Hormonal therapy*, including but not limited to androgens, anti-androgens, GnRH analogues, estrogens, and progestins (*Prior authorization requirements may apply).
 - Laboratory testing to monitor prescribed hormonal therapy
 - Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individuals' biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition).
 - Speech therapy
 - Outpatient tracheal shave procedure (chondrolaryngoplasty)
 - Gender-affirming surgeries and procedures: precertification required.
 - Requirements for "Top Surgery" (mastectomy, breast reduction or breast augmentation)
 - Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master's degree or equivalent), with written documentation submitted to the physician performing the surgery; *and*
 - Persistent, well-documented gender incongruence; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it's inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*
 - Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience); *and*
 - Capacity to make a fully informed decision and to consent for treatment; *and*
 - Age of majority (18 years of age or older)**; *and*
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
 - Top surgery generally requires associated procedures each of which should be listed for Prior Authorization separately. These include:

UTILIZATION REVIEW GUIDELINE

- Nipple-areola reconstruction
- Pectoral implants
- Skin grafts
- Note: Liposuction associated with top surgery is considered Body Sculpting Surgery, which is not a covered benefit.
- Note: Non-medical and/or cosmetic issues due to approved and performed surgery are part of the risks of this surgery and are considered Healthcare Acquired Conditions (HAC's). As such, modification procedures to correct non-medical and/or cosmetic issues due to previously approved and performed surgery is not a covered benefit.
- Requirements for “Bottom Surgery” (hysterectomy and salpingo-oophorectomy, gonadectomy or orchiectomy, and genital reconstructive surgery [vaginoplasty or female-to-male genital reconstructive surgery])
 - Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master’s degree or equivalent), with written documentation submitted to the physician performing the surgery; *and*
 - Persistent, well-documented gender incongruence; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it’s inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*
 - Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) *and*
 - Capacity to make a fully informed decision and to consent for treatment; *and*
 - Age of majority (18 years of age or older)**; *and*
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
- Bottom surgery may require associated procedures, each of which should be listed for Prior Authorization separately. These include:
 - Hysterectomy, salpingo-oophorectomy, orchiectomy
 - Vaginectomy/colpectomy, vulvectomy, metoidioplasty, phalloplasty, scrotoplasty, urethroplasty /urethromeatoplasty, insertion of testicular prosthesis
 - Vaginoplasty, electrolysis of donor site tissue to be used to line the vaginal canal or male urethra, penectomy, vulvoplasty, repair of introitus, coloproctostomy
 - Electrolysis for skin grafting
- The following are not covered benefits under Option 1:
 - Body Sculpting Surgery
 - Electrolysis other than for pre-surgical/skin grafting requirements

UTILIZATION REVIEW GUIDELINE

Guideline No: UR-001

- Facial Feminization Surgery
 - Facial Masculinization Surgery
- **Option 2: Facial feminization surgeries: precertification required**
- Requirements for FFS (facial bone reconstruction)
 - Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master’s degree or equivalent) with written documentation submitted to the physician performing the surgery; *and*
 - Persistent, well-documented gender incongruence; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it’s inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*
 - Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) *and*
 - Capacity to make a fully informed decision and to consent for treatment; *and*
 - Age of majority (18 years of age or older)**; *and*
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
 - Ancillary procedures and services beyond major facial bone reconstruction with additional requirements:
 - Services include:
 - Wrinkle removal
 - Nose procedures
 - Electrolysis of the face
 - Dermabrasion
 - Chemical peel
 - Eyelid lifts
 - Requirements for “Ancillary Procedures”
 - Two letters of referral or recommendation from qualified, licensed health professionals (with minimum of Master’s degree or equivalent) with written documentation submitted to the physician performing the surgery. The second referral should be from someone who only has an evaluative role of the individual. Two separate letters, or one letter signed by both, such as when practicing in same clinic.
 - Letters must clearly state the medical necessity for the procedures; *and*
 - Persistent, well-documented gender incongruence; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it’s inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*

- Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) *and*
 - Capacity to make a fully informed decision and to consent for treatment; *and*
 - Age of majority (18 years of age or older)**; *and*
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
- Note: The following procedures are not a covered benefit
 - Body Sculpting Surgery (BSS)
 - Facial Masculinization Surgery (FMS)
- Note: Non-medical and/or cosmetic issues due to approved and performed surgery are part of the risks of these surgeries and are considered Healthcare Acquired Conditions (HAC's). As such, modification procedures to correct non-medical and/or cosmetic issues due to previously approved and performed surgery is not a covered benefit.
- **Note for code-dependent services requiring special review and precertification under both Option 1 and Option 2**
 - Codes include unlisted/unspecified/other codes, investigational procedures, custom preparation prostheses, etc.
 - Each code will also fit under Option 1 or 2.
 - To be considered, the code must be within an Option chosen by the school/group.
 - Each code must meet the requirements for its corresponding Option (1 or 2).
 - In addition, the following information needs to be submitted for each code:
 - If it is an unlisted/unspecified/other code the following is required:
 - An accurate, detailed description of the item, service or procedure performed, as identified by an Unlisted Code
 - Documentation supporting the use of the Unlisted Code vs. other available CPT or HCPCS, if appropriate
 - All codes, including unlisted/unspecified/other code, require the following:
 - Medical necessity for service, procedure or item.
 - Supporting clinical documentation that is pertinent to the item, service or procedure performed, such as:
 - Imaging report
 - Invoice
 - Laboratory/pathology report
 - Operative/office notes
 - Procedure notes/reports

**Wellfleet will consider gender-affirming procedures for members <18 y.o. but additional prior authorization requirements may apply. For further information, contact Wellfleet's Clinical Review Team.

Attachment 2: Prior Authorization Requirements for Gender-Affirming Services for California Plans

- **Option 1:** Includes both non-precertified and precertified services below:
 - Non-procedural outpatient services and tracheal shave: no precertification required.
 - Includes the following:
 - Behavioral health services, including but not limited to counseling for gender incongruence and related psychiatric conditions (e.g., anxiety, depression)
 - Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues*, estrogens, and progestins (*Prior authorization requirements may apply).
 - Laboratory testing to monitor prescribed hormonal therapy
 - Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individuals' biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition).
 - Speech therapy
 - Outpatient tracheal shave procedure (chondrolaryngoplasty)
 - Gender-affirming surgeries and procedures: precertification required.
 - Requirements for “Top Surgery” (mastectomy, breast reduction or breast augmentation)
 - Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master’s degree or equivalent); *and*
 - Persistent, well-documented gender incongruence; *and*
 - Capacity to make a fully informed decision and to consent for treatment; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it’s inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*
 - Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) *and*
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
 - Top surgery may require associated procedures, each of which should be listed for Prior Authorization separately. These include:
 - Nipple-areola reconstruction
 - Pectoral implants
 - Skin grafts
 - Note: Non-medical and/or cosmetic issues due to approved and performed top surgery are part of the risks of this surgery and are considered Healthcare Acquired Conditions (HAC’s). As such,

modification procedures to correct non-medical and/or cosmetic issues due to previously approved and performed top surgery is not a covered benefit.

- Requirements for “Bottom Surgery” (hysterectomy and salpingo-oophorectomy, gonadectomy or orchiectomy, and genital reconstructive surgery [vaginoplasty or female-to-male genital reconstructive surgery])
 - Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master’s degree or equivalent) with written documentation submitted to the physician performing the surgery; *and*
 - Persistent, well-documented gender incongruence; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it’s inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*
 - Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) *and*
 - Capacity to make a fully informed decision and to consent for treatment; *and*
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
- Bottom surgery may require associated procedures, each of which should be listed for Prior Authorization separately. These include:
 - Hysterectomy, salpingo-oophorectomy, orchiectomy
 - Vaginectomy/colpectomy, vulvectomy, metoidioplasty, phalloplasty, scrotoplasty, urethroplasty /urethromeatoplasty, insertion of testicular prosthesis
 - Vaginoplasty, electrolysis of donor site tissue to be used to line the vaginal canal or male urethra, penectomy, vulvoplasty, repair of introitus, coloproctostomy
 - Electrolysis for skin grafting
- **Option 2: Basic facial feminization surgeries: precertification required**
 - Requirements for Basic FFS (facial bone reconstruction)
 - Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master’s degree or equivalent) with written documentation submitted to the physician performing the surgery; *and*
 - Persistent, well-documented gender incongruence; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it’s inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*
 - Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) *and*

UTILIZATION REVIEW GUIDELINE

- Capacity to make a fully informed decision and to consent for treatment; *and*
- If significant medical or mental health concerns are present, they must be reasonably well controlled
- Other procedures: Ancillary procedures, facial masculinization and body sculpting:
 - Services include:
 - Wrinkle removal
 - Nose procedures
 - Electrolysis of the face
 - Dermabrasion
 - Chemical peel
 - Eyelid lifts
 - Bone reconstruction for female-to-male members
 - Liposuction
 - Bone reconstruction other than facial bones
 - Requirements for “Other Procedures”
 - Two letters of referral or recommendation from qualified, licensed mental health professionals (with minimum of Master’s degree or equivalent) with written documentation submitted to the physician performing the surgery. The second referral should be from someone who only has an evaluative role of the individual. Two separate letters, or one letter signed by both, such as when practicing in same clinic.
 - Letters must clearly state the medical necessity for the procedures; *and*
 - Persistent, well-documented gender incongruence; *and*
 - Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it’s inconsistent with the patient's desires, goals, or expressions of individual gender identity); *and*
 - Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) *and*
 - Capacity to make a fully informed decision and to consent for treatment; *and*
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
 - Note: Non-medical and/or cosmetic issues due to approved and performed surgery are part of the risks of these surgeries and are considered Healthcare Acquired Conditions (HAC’s). As such, modification procedures to correct non-medical and/or cosmetic issues due to previously approved and performed surgery is not a covered benefit.
- **Note for code-dependent services requiring special review and precertification under both Option 1 and Option 2**
 - Codes include unlisted/unspecified/other codes, investigational procedures, custom preparation prostheses, etc.
 - Each code will also fit under Option 1 or 2.

UTILIZATION REVIEW GUIDELINE

- To be considered, the code must be within an Option chosen by the school/group.
- Each code must meet the requirements for its corresponding Option (1 or 2).
- In addition, the following information needs to be submitted for each code:
 - If it is an unlisted/unspecified/other code the following is required:
 - An accurate, detailed description of the item, service or procedure performed, as identified by an Unlisted Code
 - Documentation supporting the use of the Unlisted Code vs. other available CPT or HCPCS, if appropriate
 - All codes, including unlisted/unspecified/other code, require the following:
 - Medical necessity for service, procedure or item.
 - Supporting clinical documentation that is pertinent to the item, service or procedure performed, such as:
 - Imaging report
 - Invoice
 - Laboratory/pathology report
 - Operative/office notes
 - Procedure notes/reports



**Prior Authorization
Guideline: Gender-
Affirming**

UTILIZATION REVIEW GUIDELINE

Guideline No: UR-001

(INTERNAL USE ONLY)

**Authorization
Log**

	NAME	TITLE	SIGNATURE	DATE
Prepared by:	Barrie Baker, MD, MBA	Chief Medical Officer		10/1/20
Authorized by:	Barrie Baker, MD, MBA	Chief Medical Officer		5/25/21
Authorized by:				

**Original
Effective Date**

10/01/2020

Review Log

VERSION	DATE REVIEWED	REVIEWER NAME/TITLE	SIGNATURE	NEXT REVIEW DATE
2.0	5/25/21	Barrie Baker, MD, MBA, CMO		6/25/21
3.0	12/6/21	Barrie Baker, MD, MBA, CMO		12/1/22
4.1	3/1/23	Barrie Baker, MD, MBA, CMO		1/1/24
4.2	7/20/23	Barrie Baker, MD, MBA, CMO		1/1/24