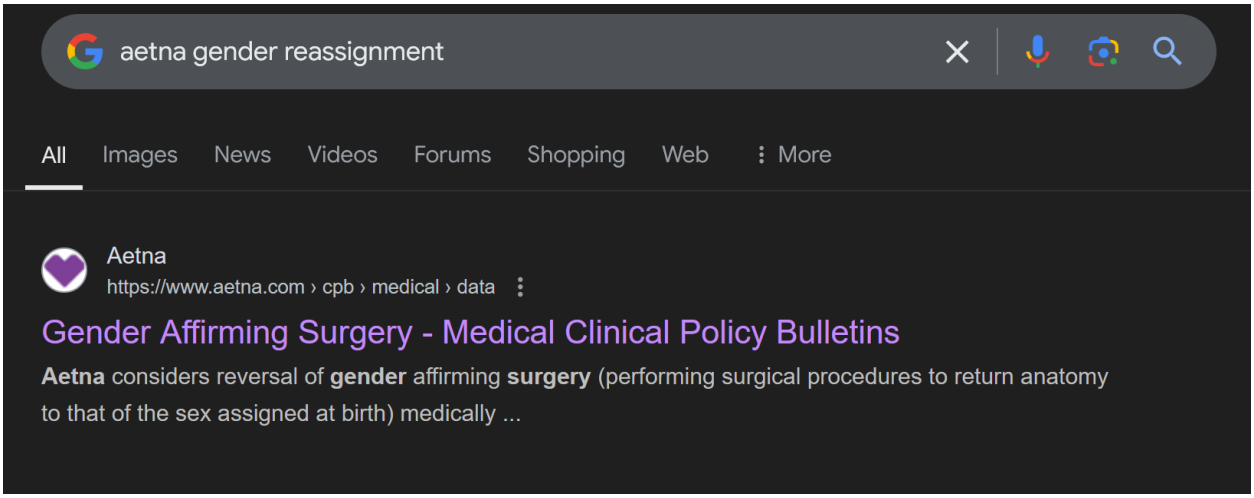
Instructions for finding your clinical criteria

The easiest (and best) way to get your plans clinical criteria is to search for it online.

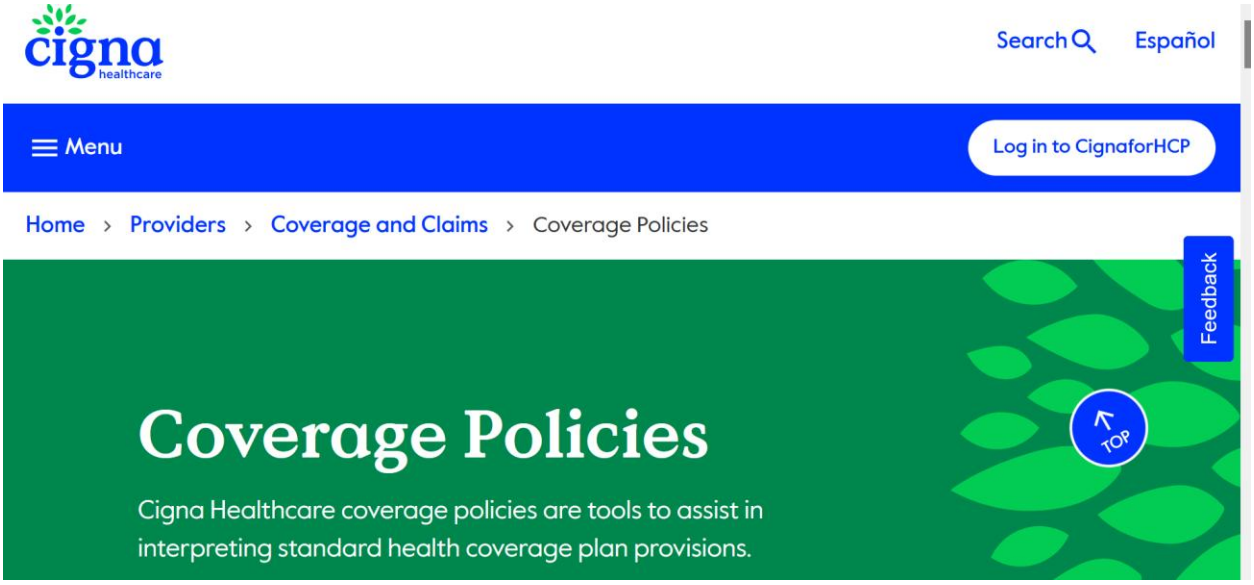
Search: [your plan name, ex. Aetna] + gender reassignment

Generally, it will be one of the first search results that pop up.

As a reminder, your plan may call the Clinical Criteria by a different name, such as Medical Coverage Policy, Clinical Policy Bulletin, etc.



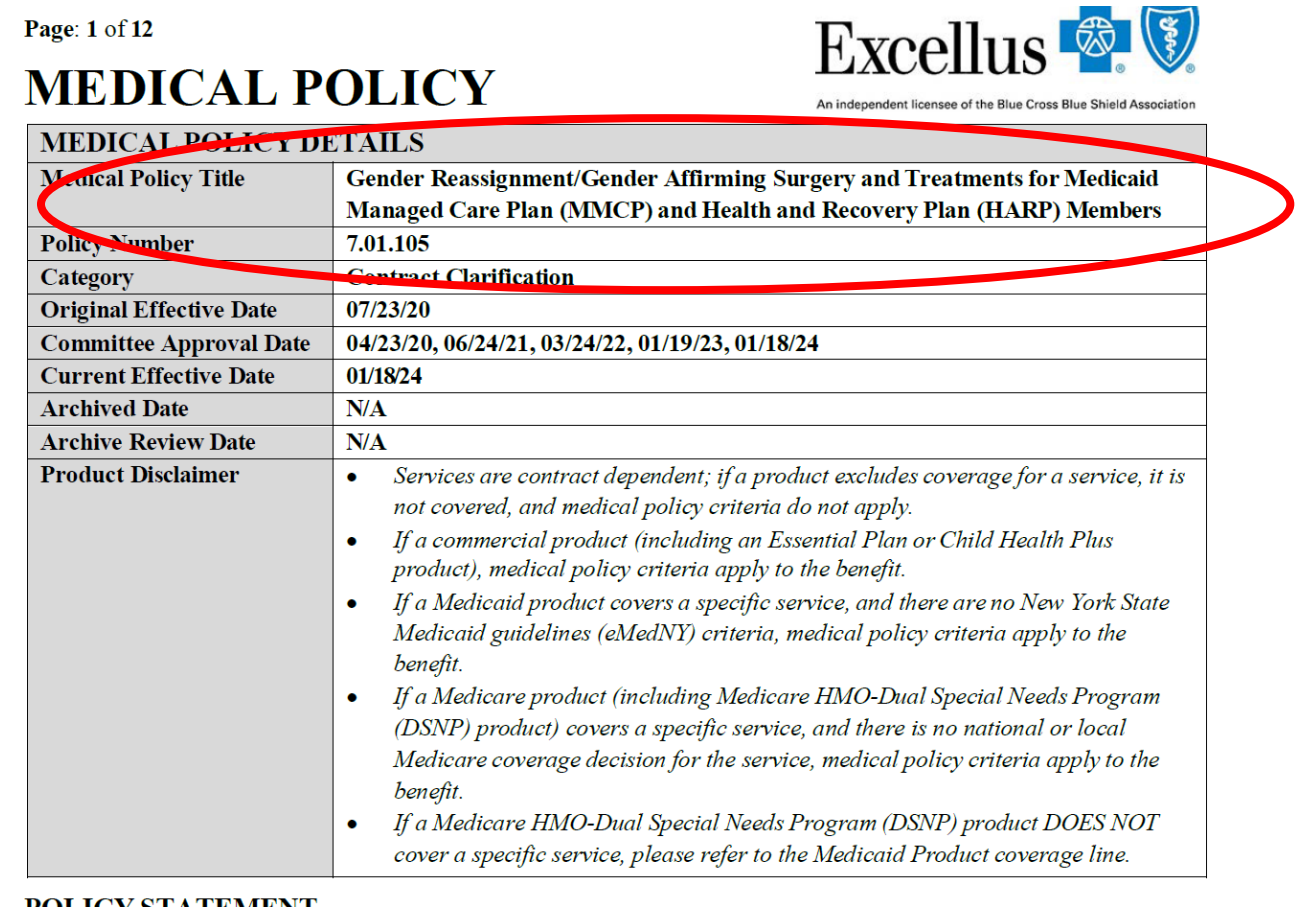
Often the clinical criteria is on the plan's website in the section for providers (doctors)



<u>Check that the clinical criteria you found applies to your plan</u>

Sometimes, plans will have different clinical criteria for different types of plans. For example, plans often have one clinical criteria for insurance you either pay for or get through an employer and a different clinical criteria document for Medicaid plans.

The clinical criteria will often list at the top of the document what type of plans it applies to.



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MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	Gender Reassignment/Gender Affirming Surgery and Treatments for Medicaid Managed Care Plan (MMCP) and Health and Recovery Plan (HARP) Members
Policy Number	7.01.105
Category	Contract Clarification
Original Effective Date	07/23/20
Committee Approval Date	04/23/20, 06/24/21, 03/24/22, 01/19/23, 01/18/24
Current Effective Date	01/18/24
Archived Date	N/A
Archive Review Date	N/A
Product Disclaimer	• *Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

Many States have passed laws and regulations that require plans to cover certain types of trans healthcare, you should check to see if the clinical criteria has different rules for the state you live in.

[reminder, if you have a Self-Insured plan or your plan is issued in a different state, the state laws and regulations of where you live may not apply to your health insurance.]

Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	Gender Dysphoria Treatment (for Indiana Only)
Kentucky	None
Louisiana	Gender Dysphoria Treatment (for Louisiana Only)
Nebraska	None
New Jersey	Gender Dysphoria Treatment (for New Jersey Only)
New Mexico	Gender Dysphoria Treatment (for New Mexico Only)
North Carolina	Gender Dysphoria Treatment (for North Carolina Only)
Ohio	Gender Dysphoria Treatment (for Ohio Only)
Pennsylvania	Gender Dysphoria Treatment (for Pennsylvania Only)
Tennessee	None
Virginia	Virginia Medicaid Department of Medical Assistance Services: Bulletin > Coverage of Gender Dysphoria Services

If you can't find your plan's clinical criteria online, you can call your plan and ask for a copy to be mailed to you. The number to call should be on the back of your insurance card. You may have to call several times to ensure that the clinical criteria is sent to you.

If you have already received a denial letter, you can use the above two options or write to your plan and request "all documents and materials used in making the adverse determination"

Your denial letter may also name the clinical criteria used to deny your request for coverage of trans healthcare, and you can specifically request that document over the phone or in writing.