

Clinical Policy: Gender-Affirming Procedures

Reference Number: OH.CP.MP.95

Last Review Date: 08/2025

[Coding Implications](#)

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Policy Statement

In compliance with Ohio Medicaid, Buckeye Health Plan must ensure coverage of medically necessary procedures. The plan covers all the services in the amount, duration, and scope that is no less than that covered by FFS Ohio Medicaid and in accordance with 42 CFR 438.210, with limitations, exclusions, and clarifications provided in the Ohio Medicaid Managed Care Provider Agreement and the Ohio Administrative Code.

Procedure

- Buckeye Health Plan will not impose hard limits or restrictions on coverage of medically necessary services.
- Prior to making a determination regarding coverage of services and procedures, Buckeye Health Plan will conduct a medical necessity review for all requests to include noncovered services and any request for services over an established benefit(s).
- Buckeye Health Plan will ensure members under age 21 have access to services that are available in accordance with federal EPSDT requirements found at 42 U.S.C. 1396d(r). This would include medically necessary services covered by Ohio Medicaid as well as any medically necessary screening, diagnostic and treatment services available to Ohio Medicaid consumers.
- Providers can request prior authorization to exceed coverage or benefit limits for members under age 21.

Description

Targeted phototherapy utilizes non-ionizing ultraviolet radiation with therapeutic benefit. Phototherapy is an efficacious local therapy that provides several advantages to traditional and biologic systemic therapies. Excimer lasers are monochromatic 308 nm xenon chloride lasers that are approved to treat certain inflammatory skin diseases. This policy describes the medical necessity requirements for excimer laser based targeted phototherapy.

Policy/Criteria

- I. It is the policy of Buckeye Health Plan ® that gender-affirming surgeries are considered medically necessary for members/enrollees when diagnosed with gender dysphoria or gender incongruence when meeting the eligibility criteria. *Note: Intersex individuals are not subject in this policy.*
 - A. Gender Dysphoria or Gender Incongruence Criteria;
 1. Marked and sustained incongruence between the member/enrollee's experienced/ gender and assigned gender, as *indicated by two or more* of the following:

- a. Marked incongruence between the member/enrollee's experienced/expressed gender and primary and/or secondary sex characteristics;
 - b. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender;
 - c. A strong desire for the primary and/or secondary sex characteristics of the other gender;
 - d. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);
 - e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender);
 - f. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender);
 - g. The condition is associated with impairment in social, occupational, or other important areas of functioning;
- B. Eligibility criteria, all of the following: Eligibility criteria to state that the over 18 section applies when medical necessity has been met in III and/or IV
1. Capacity to make a fully informed decision (including, but not limited to, awareness of the potential effects of treatment on fertility) and to consent for treatment;
 2. If significant medical or mental health concerns are present, they are reasonably well controlled;
 3. Other possible causes of apparent gender dysphoria, gender incongruence, or gender diversity have been identified and excluded;
 4. Minimum of one written statement with signature recommending gender-affirming medical and surgical treatment (GAMST) from a health care provider competent to independently assess and diagnose gender incongruence;
 5. One of the following:
 - a. For members ≥ 18 years, all of the following:
 - i. Assessment for GAMST from a provider who meets both of the following:
 - a) Has experience in or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider);
 - b) Is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated;

- ii. The documented assessment for GAMST meets all of the following:
 - a) Identifies any mental or physical health conditions that could negatively impact the outcome of GAMST, with risks and benefits discussed;
 - b) Notes the member/enrollee's capacity to understand the effect of GAMST on reproduction and includes a discussion of reproductive options with the member/enrollee prior to the initiation of GAMST;
 - iii. Member/enrollee remains stable on their gender affirming hormonal treatment regime (which may include at least six months of hormone treatment or longer if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated);
- b. For members/enrollees < 18 years, coverage is prohibited per ORC 3129.06 except for the following circumstances:
- i. The circumstances described in section 3129.04 of the Revised Code which does not prohibit a physician from treating, including by performing surgery on or prescribing drugs or hormones for, a minor individual who meets any of the following:
 - a) Was born with a medically verifiable disorder of sex development, including an individual with external biological sex characteristics that are irresolvably ambiguous, such as an individual born with forty-six XX chromosomes with virilization, forty-six XY chromosomes with undervirilization, or having both ovarian and testicular tissue;
 - b) Received a diagnosis of a disorder of sexual development, in which a physician has determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a biological male or biological female;
 - c) Needs treatment for any infection, injury, disease, or disorder that has been caused or exacerbated by the performance of gender transition services, whether or not the services were performed in accordance with state or federal law.
 - ii. Mental health services provided for a gender-related condition
 - iii. Any services that are not gender transition services

- II.** It is the policy of Buckeye Health Plan that gender affirming facial procedures will be considered for medical necessity on a case-by-case basis when meeting the following:
- A. Criteria has been met in section I.A. I. B.;

- B. Requested procedure intends to correct existing facial appearance that demonstrates significant variation from standard appearance for the experienced gender. For members/enrollees >18 years, 12 months of hormone therapy is required prior to facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or medically contraindicated. Possible procedures include, but are not limited to, the following:
1. Blepharoplasty;
 2. Face lift/mid-face lift/brow lift;
 3. Facial implants and bone reconstruction;
 4. Hair removal/electrolysis;
 5. Drugs for hair loss or growth
 6. Hair transplantation or hairline advancement;
 7. Prosthetic or filler substances to alter contour;
 8. Rhinoplasty;
 9. Thyroid chondroplasty;
 10. Removal of redundant skin;
 11. Upper lip shortening and lip augmentation;
 12. Chondrolaryngoplasty;
 13. Voice modification surgery, therapy, or lessons
- C. For members < 18 years old, only circumstances that are considered for medical necessity review are mentioned above in I.B.5.b
- III.** Any member 18 to 20 years of age, as per 42 CFR § 441.56 and 42 U.S.C. § 1396d(r), will be reviewed for medical necessity as required by the EPSDT program (ie, Ohio Healthchek). Plan will cover medically necessary care if deemed essential by a healthcare provider, including gender-related care.
- IV.** For any member 21 years of age or older, Ohio Administrative Code § 5160-2-03 establishes that gender transformation services are not covered services. It is the policy of Buckeye Health Plan that the following procedures, when used to improve the gender specific appearance of a member/enrollee undergoing gender affirmation are not medically necessary, as they are considered cosmetic in nature (not an all-inclusive list):
1. Abdominoplasty
 2. Mastopexy
 3. Liposuction
 4. Skin resurfacing
 5. Revision procedures for purposes other than correction of complications
- V.** All behavioral health services for gender dysphoria will be subject to the same utilization management and cost-sharing requirements as other behavioral and medical benefits in compliance with Mental Health Parity and Addiction Equity Act. 42 U.S.C. § 300gg-26; 45 C.F.R. Part 146.

Background

The World Professional Association for Transgender Health (WPATH) is an international professional society dedicated to promoting the highest level of evidence-based principles for transgender and gender diverse (TGD) individuals.¹ Gender identity is a person's deepest inner sense of being female or male, which for many is established by the age of two through three years. *Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.² *Gender dysphoria* refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).^{2,3} Per WPATH, the focus of gender dysphoria is not on the individual's gender identity, but on any of the distress or discomfort related to being TGD.¹ WPATH states that gender incongruence is considered a condition with a focus on the TGD person's experienced identity and any need for gender-affirming treatment that arises from this identity.¹

Treatment to assist people with gender dysphoria is available and can help to find the gender identity and role that is comfortable for them. Treatment is very individualized and may or may not involve gender-affirming surgery or body modification. Treatment options include changes in gender expression and role; hormone therapy to feminize or masculinize the body; surgery to change primary and/or secondary sex characteristics; and psychotherapy. Many people who receive treatment for gender dysphoria will find a gender role and expression that is comfortable for them, regardless of whether they differ from the sex assigned to them at birth.

WPATH's Standards of Care (SOC) are a series of flexible guidelines for clinical practice published by the society and are based on evidence and expert consensus.¹ Version 8 of WPATH's SOC were published in 2022, and these guidelines offer clinical guidance to health care professionals caring for TGD people and are intended to be adaptable to meet the diverse health care needs of this population.

WPATH recommends that the assessment for gender-affirming medical and surgical treatment (GAMST) in individuals < 18 years old be completed by a provider who is licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution. The provider(s) working with gender diverse adolescents should additionally meet all of the following.¹

1. Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum;
2. Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span;
3. Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/ neurodivergent gender diverse adolescents;

4. Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families;
5. Complete a comprehensive biopsychosocial assessment of the adolescent member/enrollee presenting with gender identity-related concerns and seek medical/surgical transition-related care in a collaborative and supportive manner;
6. Maintain an ongoing relationship with the gender diverse and transgender adolescent member/enrollee and any relevant caregivers to support the adolescent in their decision making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care;
7. Involve parent(s)/guardian(s) in the GAMST assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible;
8. Involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

WPATH recommends that the assessment for GAMST in adults ≥ 18 years of age be completed by a provider who is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider). The provider(s) working with gender diverse adults should additionally meet all of the following¹:

1. Identify co-existing mental health or other psychosocial concerns, distinguishing these from gender dysphoria, incongruence, and diversity;
2. Assess capacity to consent for treatment (capacity to consent is required for GAMST assessment);
3. Have experience or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity and is able to liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required;
4. Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments;
5. Ensure any mental or physical health conditions that could negatively impact the outcome of GAMSTs are assessed, with risks and benefits discussed, before a decision is made regarding treatment;
6. Assess the member/enrollee's capacity to understand the effect of GAMST on reproduction and discuss reproduction options with the member/enrollee prior to the initiation of GAMST;
7. Assess and discuss the role of social transition with the member/enrollee requesting GAMST.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are

from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
11950 through 11954	Subcutaneous injection of filling material (eg, collagen)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent implant
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15600	Delay of flap or sectioning of flap (division and inset); at trunk
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, feet
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780 through 15783	Dermabrasion
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal

CPT® Codes	Description
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820 through 15823	Blepharoplasty
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832 through 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876 through 15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi

CPT® Codes	Description
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty reconstruction female urethra
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular) with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall;
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy, complete removal vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction artificial vagina; without graft
57292	Construction artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach

CPT® Codes	Description
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral
58999	Unlisted procedure, female genital system (nonobstetrical)
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed; specialist reviewed	07/25	08/25

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Buckeye Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g. evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by Buckeye Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation

shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of Buckeye Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for coverage provisions pertaining to this clinical policy.