From: Chechi, Munir@DMHC
To: [redacted]
Subject: Health and Safety Code Section 1365.5 Compliance
Date: Thursday, February 05, 2015 1:43:00 PM
Attachments: IGNA APL Final.doc

This e-mail is being sent to all applicable health care service plans in order to provide information regarding compliance filings related to Section 1365.5.

Attached you will find an All Plan Letter dated February 5, 2015 that has been provided for simplification of filing.

The Department would appreciate receipt of the Section 1365.5 filings within ninety (90) days of the date of this letter.

If you have any questions related to this request, please feel free to contact your Office of Plan Licensing reviewer.

Thank you for your attention to this matter.

Regards,

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Deputy Director
Office of Plan Licensing
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State of California
Health and Human Services Agency
Department of Managed Health Care

ALL PLAN LETTER

DATE: February 5, 2015

TO: All Full-Service Health Plans

FROM: Nancy Wong
Deputy Director, Office of Plan Licensing

SUBJECT: HEALTH AND SAFETY CODE SECTION 1365.5 COMPLIANCE

The Director of the Department of Managed Health Care (the "Department") issued Letter No. 12-K ("Director's Letter"), which was effective on April 9, 2013. Subsequent to the implementation of the Director's Letter, the Department monitored consumer complaints, Independent Medical Review ("IMR") data, and input received from stakeholders, including the transgender community and the California Association of Health Plans.

Enrollees diagnosed with gender dysphoria must be treated in the same manner as any other enrollee when a service is requested. Health plans are required to apply clinical standards consistently. The appropriate grievance, appeal and IMR[1] processes will continue to be available to all enrollees. No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment.

The Department is now directing health plans to review their EOCs, including riders, even if previously approved or not objected to by the Department, and to revise their EOCs if necessary to be consistent with the following:

- Define the terms "cosmetic surgery" and "reconstructive surgery" consistently with section 1367.63 of the Act. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) To improve function; (B) To create a normal appearance, to the extent possible.

[1] The Department confirms that medical professionals selected to review medical treatment decisions in the Independent Medical Review (IMR) process shall be clinicians knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment and familiar with the guidelines and protocols in the area of treatment under review as required by section 1374.32(d)(4)(A). Pursuant to SB 1410, the standard as of July 1, 2015, will change to the following: "The medical professional shall be a clinician expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating patients with the same or a similar medical condition as the enrollee."

- Omit lists of surgeries that are universally excluded from coverage or examples of non-covered surgeries in both the reconstructive surgery benefit and the cosmetic surgery exclusion.
- Omit limitation of surgery to "one per lifetime" or any other limitation that is not supported by sound clinical principles or that creates unreasonable barriers to receiving medically necessary or reconstructive surgery.[2]

Health plans should e-file their EOCs as an Amendment within ninety (90) days of the date of this letter, revising any impermissible language. The title of the filing should be "IGNA EOC Compliance." Please file the entire EOC, including riders, and not just the pages the plan is revising. If the plan believes its documents do not require revision, the plan should file an E-1 confirming that belief and either file a current EOC or refer to a filing number with a current complete EOC so that the Department can confirm compliance. All filings should highlight as well as underline the changes to the text as required by Rule §1300.52(d).

If you have any questions about submitting your health plan's filing, please don't hesitate to contact the Office of Plan Licensing through your assigned counsel.

[2] Section 1363.5(b) requires health plan criteria or guidelines to:
(1) Be developed with involvement from actively practicing health care providers.
(2) Be consistent with sound clinical principles and processes.
(3) Be evaluated, and updated if necessary, at least annually.
(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.