Department:	Medical Management	**Original Approval:**	07/19/2018
Policy #:	MM166	**Last Approval:**	07/24/2018
Title:	Gender Transition Policy		
Approved By:	UM Medical Subcommittee		

REQUIRED CLINICAL DOCUMENTATION FOR REVIEW

1. Clear documentation of the diagnosis of Gender Dysphoria must be provided.
2. Medical records required from all of the following:
   a) Two licensed mental health professionals (only one needed for Female to Male chest surgery)
   b) The medical provider who has managed the hormone therapy, primary care and/or transgender services
   c) The surgeon(s) recommending the surgical procedures
3. Clear evidence of a comprehensive, patient-centered plan of care with coordination between the care team and consent of the member must include the following:

a) Plan of care documentation must include the patient's signature to document understanding of the treatment plan, surgical treatment, risks and benefits of the surgery; and

A comprehensive referral letter for surgery, written and signed by a member of the treatment team, with a prior authorization request for surgery must be submitted to the plan.

BACKGROUND

The category of Gender Reassignment Surgery (GRS) includes:

1. Breast/chest surgeries;
2. Genital surgeries;
3. Other surgeries.

For the Male-to-Female (MTF) patient, surgical procedures may include the following:

1. Breast/chest surgery: mammaplasty
2. Genital surgery: orchiectomy, penectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty, prostatectomy
3. Other procedures: facial reconstruction surgery, electrolysis or laser hair removal, thyroid cartilage reduction, hair reconstruction, voice surgery.

For the Female-to-Male (FTM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, nipple grafts, chest reconstruction
2. Genital surgery: hysterectomy/salpingo-oophorectomy, metoidioplasty, phalloplasty (employing a pedicled or free vascularized flap), reconstruction of the fixed part of the of the urethra, vaginectomy, vulvectomy, scrotoplasty, implantation of erectile and/or testicular prostheses
3. Other procedures (rare): voice surgery

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DEFINITIONS

The following are synonyms:

- Gender Reassignment Surgery
- Gender Confirming Surgery
- Gender Transition Surgery

Breast/chest surgeries:

- Mammaplasty: surgical creation of the female breast.
- Mastectomy: Surgical removal of the breast.

Genital surgeries:

- Clitoroplasty: surgical creation of a clitoris.
- Labiaplasty: surgical creation of the labia.
- Hysterectomy: surgical removal of the uterus.
- Metoidioplasty: female-to-male gender reassignment surgery
- Orchiectomy: surgical removal of the testes.
- Penectomy: surgical removal of the penis.
- Phalloplasty: surgical creation of a penis.
- Prostatectomy: surgical removal of the prostate.
- Salpingo-oophorectomy: surgical removal of the fallopian tubes and ovaries.
- Scrotoplasty: surgical creation of a scrotum.
- Urethroplasty: surgical creation of the urethra.
- Vaginectomy: surgical removal of the vagina.
- Vaginoplasty: surgical creation of a vagina.
- Vulvectomy: surgical removal of the vulva.
- Vulvoplasty: surgical creation of a vulva.

INDICATIONS/CRITERIA

Medicaid Members	Surgery is not covered by CHPW but is covered as fee-for service by the HCA.
Medicare Members	See below for criteria

For WA Apple Health Members:
CHPW covers hormone therapy and mental health services related to gender transition.
Most surgical services are covered by fee-for-service, through the HCA. Prior Authorization by the Health Care Authority is required and CHPW is unable to facilitate this prior authorization.
https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/transgender-health-program

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Criteria For Gender Transition Surgery For Apple Health Members
The HCA has their own criteria and must evaluate all requests.

For Medicare Members:
Indications for Gender Reassignment Surgery
These criteria do not apply to patients who are having these procedures for medical indications other than Gender Dysphoria.

Gender reassignment surgery may be considered **medically necessary** in the treatment of gender dysphoria when **all** of the following criteria are met:

1. Age at least 18 years. For patients younger than 18 years of age, mastectomy may be considered medically necessary in female to male surgical procedures. Other requirements outlined in this Section must be met to proceed with surgery in those younger than 18 years of age.

2. Clinical records document that the patient has the capacity to make fully informed decisions and consent for treatment, and as part of a comprehensive, patient-centered treatment plan; and that any other mental health condition, if present, is adequately controlled.

3. The multidisciplinary treatment team must have documented the diagnosis of gender dysphoria and recommend surgical treatment as part of a comprehensive, patient-centered plan of care. The plan of care and recommendation for surgical treatment must meet the criteria in A through D below.

a. The multidisciplinary treatment team consists of the following: two licensed mental health professionals*, the medical provider who has managed the hormone therapy and primary medical care and/or transgender services prior to surgical evaluation, and the surgeon(s) recommending the surgical procedures; and
*Only one mental health professional referral is required for mastectomy in female to males.

b. A surgical evaluation by a surgeon(s) who will perform the gender reassignment surgery as part of a comprehensive, patient-centered plan of care. Upon completion, the surgeon must forward the results of the surgical evaluation and recommendations for surgical treatment to other treatment team members; and

c. Plan of care documentation must include the patient's signature to document understanding of the treatment plan, surgical treatment, risks and benefits of the surgery; and

d. A comprehensive referral letter for surgery, written and signed by a member of the treatment team, with a prior authorization request for surgery must be submitted to the plan.

4. Documentation of continuous hormonal therapy for at least 12 months, unless there is a documented contraindication to hormonal therapy. Hormonal therapy is not required prior to mastectomy in female-to-males.

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5. Twelve months of living in a gender role that is congruent with the patient's gender identity.

6. If the referring medical provider or mental health provider requests surgical intervention prior to the patient's completion of 12 months of hormone therapy and living in desired gender, the multidisciplinary treatment team must submit evidence of medical necessity and clear rationale for the proposed surgical intervention. The multidisciplinary treatment team must submit written documentation to the plan that includes:

a. A comprehensive, coordinated treatment plan with evidence that all treatment plan criteria for surgery and treatment goals have been met; and

b. Clear rationale for the variation from the 12-month period for either/or hormone therapy and living in desired gender; and

c. Documentation that the proposed surgical provider accepts the treatment plan and surgical intervention proposed by the coordinated clinical team's treatment plan with less than 12 months living in desired gender and on hormone therapy; and

d. Patient understands the treatment plan, risks and benefits of surgery prior to completing the 12-month period; and

e. The plan will determine authorization and consent to care based on medical necessity from the documentation outlined in II.A.

For breast/chest surgeries:
Hormone therapy is not a prerequisite for FTM patients. For MTF patients, it is recommended that MTF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery, unless clinically contraindicated.

Limitations of Coverage

- No surgery should be performed while a patient is actively psychotic.
- Excluded procedures include lipectomy of upper limbs, neck, and head; excision of excessive skin and subcutaneous tissue from abdomen, thigh, leg, hip, buttock, arm, forearm or hand.
- Reversal of gender transition surgery is not covered.
- Storage of sperm, oocytes, or embryos is not covered.

SPECIAL CONSIDERATIONS

Enter all special considerations here.

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LIMITATIONS/EXCLUSIONS

Please refer to a product line's certificate of coverage for benefit limitations and exclusions for these services:

PRODUCT LINE	LINK TO CERTIFICATE OF COVERAGE
MEDICARE ADVANTAGE	http://healthfirst.chpw.org/for-members/resource-library/handbooks-and-guides
WASHINGTON APPLE HEALTH	http://chpw.org/our-plans/apple-health/
INTEGRATED MANAGED CARE	http://chpw.org/our-plans/apple-health/

Citations & References

CFR		
WAC		
RCW		
Contract Citation	☒ WAH	
	☒ IMC	
	☒ MA	Department of Health and Human Services DEPARTMENTAL APPEALS BOARD Appellate Division NCD 140.3, Transsexual Surgery Docket No. A-13-87 Decision No. 2576 May 30, 2014
Other Requirements		
NCQA Elements		

Revision History

Revision Date	Revision Description	Revision Made By
07/19/2018	Original draft	LuAnn Chen, MD
07/24/2018	Approved	UM Medical Subcommittee

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