Department:	Medical Management	**Original Approval:**	07/24/2018
Policy No:	MM166	**Last Approval:**	02/14/2024
Policy Title:	Gender Affirming Care Clinical Coverage Criteria		
Approved By:	UM Criteria Subcommittee		
Applicable Line(s) of Business:	☒ **Washington Apple Health (Medicaid)** ☒ **Behavioral Health Services Only** ☐ **Apple Health Expansion** ☐ **State Medicaid Agency Contract (SMAC)** ☐ **Health Homes** ☒ **Medicare Advantage/Special Needs Plan** ☒ **Cascade Select**		

Special Notes:

CHPW covers hormone therapy, mental health services and preventive services related to gender affirmation without prior authorization. The criteria listed in this policy pertain to prior authorization for gender-affirming surgical procedures for Medicare and Cascade Select members. All gender affirming surgery services and procedures for Medicaid members with a primary diagnosis of gender dysphoria (F64.0, F64.1, F64.2, and F64.9) are excluded from CHPW and are covered and processed by the Health Care Authority (HCA) Fee-For-Service (FFS).

Members who require a surgical procedure for a co-existing medical condition and gender dysphoria is a secondary diagnosis, prior authorization requests will be reviewed by CHPW using MM141 Reconstructive Plastic Surgery or MCG as the criteria.

Required Clinical Documentation for Review

1. Medical records required from all the following:
    a) Two licensed mental health professionals (only one needed for top surgery with or without chest reconstruction)
    b) The medical provider who has managed the hormone therapy, primary care and/or gender affirming care
    c) The surgeon(s) recommending the surgical procedures

2. Clinical documentation must address all the medical necessity criteria listed in the "Criteria/Indications" section of this policy

3. Details of any specific needs related to risk/trauma/cultural etc.

Background

Gender Incongruence refers to a marked and persistent incongruence between an individual's experienced gender and the sex assigned to them at birth based upon external genitalia. Gender Dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth, where the degree of distress is clinically significant or causes impairment in social, occupational, or other critical areas of functioning. Only some people with gender incongruence experience gender dysphoria at some point in their lives. Gender incongruence is not limited to individuals who identify as strictly male or female, but includes individuals who may identify as non-binary, somewhere in between male and female, or altogether different from sexes typically assigned at birth.

Gender incongruence and gender dysphoria can largely be alleviated through psychosocial and medical interventions. These may include any or all the following: Changes in social gender expression, family and social supports, psychotherapy, hormone, and other therapies to align the body with gender identity, and surgery to change primary and/or secondary sex characteristics.

Definitions

The following are synonyms:

1. Gender Affirming Surgery
2. Gender Confirming Surgery
3. Gender Transition Surgery

Masculinization or defeminization procedures:

1. Chest (top) surgery (e.g., mastectomy, masculinizing chest surgery)
2. Genital surgery (e.g., metoidoplasty, phalloplasty, scrotoplasty, vaginectomy, testicular prosthesis, penile prosthesis)
3. Hysterectomy with or without oophorectomy
4. Facial masculinization (e.g. rhinoplasty, facelift, contouring or augmentation of jaw, chin, forehead)

5. Other aesthetic procedure when existing appearance varies significantly from that of experienced gender (e.g., body contouring)
6. Voce procedure (e.g., vocal cord injection, thyroplasty type III) if testosterone therapy and voice training insufficient)

Feminizing or demasculinizing procedures:

1. Breast augmentation (mammoplasty)
2. Genital surgery (e.g., vaginoplasty, Vulvoplasty)
3. Orchiectomy
4. Facial and neck feminization, (e.g., brow reduction, chondrolaryngoplasty, rhinoplasty, hair removal, augmentation of jaw, chin, forehead)
5. Other aesthetic procedures when existing appearance varies significantly from that of experienced gender (e.g., body contouring
6. Voice procedure (e.g., glottoplasty, laryngoplasty, cricothyroid approximation, laser-assisted voice adjustment)

Specific Genital surgeries:

1. Clitoroplasty: surgical creation of a clitoris.
2. Labiaplasty: surgical creation of the labia.
3. Hysterectomy: surgical removal of the uterus.
4. Metoidioplasty: surgical creation of a penis using clitoral tissue
5. Orchiectomy: surgical removal of the testes.
6. Penectomy: surgical removal of the penis.
7. Phalloplasty: surgical creation of a penis.
8. Prostatectomy: surgical removal of the prostate.
9. Salpingo-oophorectomy: surgical removal of the fallopian tubes and ovaries.
10. Scrotoplasty: surgical creation of a scrotum.
11. Urethroplasty: surgical creation of the urethra.
12. Vaginectomy: surgical removal of the vagina.
13. Vaginoplasty: surgical creation of a vagina.
14. Vulvectomy: surgical removal of the vulva.
15. Vulvoplasty: surgical creation of a vulva.

Indications/Criteria

For AH Members:

CHPW covers hormone therapy, mental health services and preventive services related to gender affirmation.

All gender affirming surgery services and procedures for Medicaid members with a primary diagnosis of gender dysphoria (F64.0, F64.1, F64.2, and F64.9) are excluded from CHPW and are covered and processed by the Health Care Authority (HCA) Fee-For-Service (FFS).

Members who require a surgical procedure for a co-existing medical condition and gender dysphoria is a secondary diagnosis, prior authorization requests will be reviewed by CHPW using MM141 Reconstructive Plastic Surgery or MCG as the criteria.

UM Process when Gender Affirming Health Service request is received for AH Member:

1. Validate the request;
2. If the requested service is gender affirming surgery, contact the requesting provider and inform that these services are covered under HCA's Fee-For-Service. Have the provider contact HCA to have the authorization initiated.
3. Refer to Case Management for care coordination and guidance for member and provider in obtaining needed services for the member.
4. Send Excluded Services Notice letter to both the Member and Provider.
5. Document in Jiva.
6. Void the request and enter Entered in Error decision.

For BHSO Members

CHPW covers behavioral health services related to gender dysphoria and gender affirmation.

Hormonal prescriptions and surgical services are covered through the member's medical insurance. Prior Authorization for surgeries should be requested through the member's medical insurance and CHPW is unable to facilitate the prior authorization.

For Medicare and Individual & Family (Cascade Select) Members:

There is no LCD/NCD for this service.

Hormone therapy, electrolysis, mental health services, surgeries, and preventive services related to gender affirmation are all covered if they are medically necessary.

Criteria/Indications for Gender Affirming Surgery

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

1. At least 18 years of age, with exception of mastectomy for Masculinization. Mastectomy can be considered regardless of age.
2. Clinical records document that the member has the capacity to make fully informed decisions and consent for treatment, 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 or marked and persistent gender incongruence 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/non-binary services prior to surgical evaluation, and the surgeon(s) recommending the surgical procedures; and

       *Only one mental health professional referral is required for chest surgery with or without reconstruction

    b. A surgical evaluation by a surgeon(s) who will perform the gender affirming 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 member'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. One of the following regarding hormonal therapy and living in a gender congruent role:
    a. Documentation of continuous hormonal therapy and of living in a gender role that is congruent with the member's gender identity for at least 12 months, unless the member has:
        i. Documented contraindication to hormonal therapy; and/or
        ii. Safety concerns/risks that do not allow the member to live in their gender identity; or
        iii. The requested surgery is top surgery, orchiectomy, or hysterectomy.

b. If the referring medical provider or mental health provider requests gender affirming surgical intervention prior to the member's completion of 12 months of hormone therapy and living in a gender role that is congruent with the member's gender identity, the multidisciplinary treatment team must submit evidence of medical necessity and clear rationale for the proposed surgical intervention that includes all the following:

i. A comprehensive, coordinated treatment plan with evidence that all treatment plan criteria for surgery and treatment goals have been met; and
ii. Clear rationale for the variation from the 12-month period for either/or hormone therapy and living in a gender role that is congruent with the member's gender identity; and
iii. 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 a gender role that is congruent with the member's gender identity and on hormone therapy; and
iv. The member understands the treatment plan, risks, and benefits of surgery prior to completing the 12-month period

For breast/chest surgeries:

Hormone therapy is not a prerequisite for Chest masculinization surgery. It is recommended that feminizing hormone therapy be taken for a minimum of 12 months prior to breast augmentation surgery, unless clinically contraindicated.

Limitations of Coverage:

1. No surgery should be performed while a member is actively psychotic.
2. 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.
3. Reversal of gender affirming surgery is not covered.
4. Storage of sperm, oocytes, or embryos is not covered.
5. Revision of previous gender affirming surgery may be considered if medically necessary.

Special Considerations

All members requesting gender affirming surgical services will be referred to CHPW Case Management to help with navigation and to ensure coordination of care.

Limitations/Exclusions

Please see link to member coverage documents below:

Line of Business	Link to Member Coverage Documents
Medicare Advantage	https://medicare.chpw.org/ Select the appropriate plan from the "Plans" drop down on the top navigation bar.
Apple Health	https://www.chpw.org/for-members/benefits-and-coverage-imc/
Cascade Select	https://chnwhealthinsurance.chpw.org/member-center/plan-benefits/

List of Appendices

None.

Citations & References

CFR		
WAC	284-43-5642; 182-531-1675	
RCW		
LOB & Contract Citation	☒ **WAHIMC** ☒ **BHSO** ☐ **Wraparound** ☐ **SMAC** ☐ **HH**	IMC Section 1.177: Medically Necessary Services; IMC Section 11.1: Utilization Management General Requirements; IMC Section 11.4: Medical Necessity Determination; IMC Section 11.5.6.2: The Contractor will support Enrollee access to gender affirming treatment; IMC Section 17.1.10.19: Hormone therapy for any transgender Enrollees and puberty-blocking treatment for transgender adolescents consistent with HCA's gender dysphoria treatment benefit.
	☐ **AHE**	
	☒ **MA/DSNP**	
	☒ **CS**	

Other Requirements	
NCQA Elements	UM 2, UM 5
References	World Professional Association for Transgender Health Standards of Care 8

Revision History

Revision Date	Revision Description	Revision Made By
07/19/2018	Original draft	LuAnn Chen, MD
07/24/2018	Approved	UM Medical Subcommittee
07/31/2019	Approved	UM Committee
06/03/2019	Links checked. Reviewed, no changes. Corrected the missed documentation of approval on 7/31/2019 by UM Committee	LuAnn Chen, MD
07/05/2019	Approval	UM Medical Subcommittee
02/04/2020	Added list of Transgender Health services. Added how UM shall process requests when received. Updated MTF and FTM surgical procedures	Yves Houghton, RN
02/12/2020	WAH-IMC and MA Contract Citations updated	LuAnn Chen, MD
02/20/2020	Approval	UM Medical Subcommittee
08/12/2020	Added referral to CM for AH-IMC members. Added criteria for CHNW Cascade Select members. Clarified that all members requesting these services will be referred to CM.	LuAnn Chen, MD
09/10/2020	Approval	UM Medical Subcommittee
10/05/2020	Clarified that AH-IMC members must receive a denial for non-covered surgical procedures.	Justin Fowler, RN
10/06/2020	The changes are based on the WPATH Standards of Care and Bree Collaborative LGBTQ Health Care Recommendations will be presented to CQIC on 10/13/2020 for potential adoption into Clinical Practice Guidelines: changed name of policy from Gender Transition Policy to Transgender Health Policy, changed terminology to gender affirming	LuAnn Chen, MD

	surgery, clarified coverage of electrolysis and preventive services related to gender affirmation. Added NCQA elements and formatting changes.	
10/07/2020	Approval	CMO Cabinet
05/17/2021	Corrected citations, added WAC 182-531-1675.	LuAnn Chen, MD
09/15/2021	Reviewed, minor edits and updates to citations.	LuAnn Chen, MD
10/01/2021	Approval	UM Medical Subcommittee
08/24/2022	Reviewed, minor edits and updates to citations.	LuAnn Chen, MD
08/26/2022	Added verbiage that HCA FFS covers gender-affirming surgery for Medicaid member with primary dx of gender dysphoria. If the member requires a surgical procedure for a co-existing medical condition and gender dysphoria is a secondary diagnosis, the PA request will be processed by CHPW. Updated UM process for Medicaid.	Yves Houghton, RN
09/12/2022	Approval	UM Medical Subcommittee
02/09/2023	Corrected that HCA covers electrolysis for AH members. Updated WPATH to SOC 8 and reviewed for alignment with this CPG. Removed CHNW references. Updated citations.	LuAnn Chen, MD
05/24/2023	Approval	UM Medical Subcommittee
01/10/2024	Reviewed and edited by CHPW LGBTQIA+ Subject Matter Expert to ensure WPATH alignment.	Manda Lyons
01/12/2024	Updates to citations. Changed title. Clarified absence of LCD/NCD.	LuAnn Chen, MD
01/16/2024	Added initial notes, updated background and definitions, removed references to specific gender-binary transition states, streamlined duplicated content	Tawnya Christiansen, MD
02/14/2024	Approval	UM Criteria Subcommittee