



IEHP UM Subcommittee Approved Authorization Guideline			
<b>Guideline</b>	Gender Dysphoria	<b>Guideline #</b>	UM_SUR 04
		<b>Original Effective Date</b>	5/14/2014
<b>Section</b>	Surgery	<b>Revision Date</b>	03/28/19

## COVERAGE POLICY

IEHP considers the following treatment medically necessary for Members with gender dysphoria:

1. Behavior health services, to include psychotherapy;
2. Feminizing/masculinizing hormone therapy and/or puberty suppression hormone therapy with clinical monitoring for efficacy and adverse events; and
3. Gender-affirmation surgery that is not cosmetic in nature.

### Qualification Process of Gender-Affirming Treatments and Procedures:

**Members 18 years of age or older:**

#### **A. Hormone Therapy**

1. The individual must have a diagnosis of gender dysphoria.
2. The individual must be able to provide informed consent. Feminizing/masculinizing hormone therapy may lead to irreversible physical changes and/or adverse effects. The individual must have the capacity to make a fully informed decision to consent to treatment. This should include a discussion regarding options for fertility preservation.
3. It is recommended that the individual be in therapy with a mental health professional.
  - a. The mental health professional must have at a minimum a master's degree or its equivalent in a clinical behavioral science field by an accredited institution, an up-to-date clinical license, training, continuing education and experience working with the diagnosis and treatment of gender dysphoria.
4. The medical provider prescribing the gender-affirming hormones may be a Primary Care Physician, an Obstetrician-Gynecologist, an Endocrinologist, or another medical professional with a license to prescribe hormones.
  - a. The goal of trans-feminizing hormone therapy is the development of female secondary sex characteristics, and suppression/minimization of male endogenous secondary sex characteristics.
  - b. The goal of trans-masculinizing hormone therapy is the development of male secondary sex characteristics, and suppression/minimization of female endogenous secondary sex characteristics.

**B. Chest and Genital Gender-Affirming Surgical Consultation:**

1. The individual must have a diagnosis of persistent gender dysphoria.
2. The individual must be able to provide informed consent. Feminizing/masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment.
3. A Medical Evaluation Form is to be completed (see Attachment B). Alternatively, the Provider may submit the same content in the clinical documentation.
4. The Provider or Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (see Attachment C). Alternatively, a letter from the Provider addressing the same content as Attachment C is acceptable.
  - a. **One form/letter (for chest surgeries)** from an individual's treating Primary Care Provider or mental health professional endorsing the request in writing is required for the following chest surgeries:
    - i. (M to F) Augmentation mammoplasty;
    - ii. (F to M) Mastectomy with male chest reconstruction.
  - b. **Two forms/letters (for genital surgeries)** from an individual's Primary Care Provider and/or mental health professional(s) endorsing the request in writing are required for the following genital surgeries:
    - i. (M to F) Penectomy, orchiectomy, vaginoplasty, colovaginoplasty, clitoroplasty, vulvoplasty, and labioplasty;
    - ii. (F to M) Hysterectomy, salpino-oophorectomy, urethorplasty, metoidioplasty, phalloplasty, vaginectomy, scrotoplasty, penile implant, testicular prosthesis.
5. For all genital surgeries, the individual must have undergone 12 months of continuous hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual.)
6. For vaginoplasty, metoidioplasty, and phalloplasty, the individual must have been living in the gender role congruent with the patient's gender identity for 12 continuous months.
7. It is strongly recommended that a social health assessment that screens the Member for social needs such as housing, food, transportation, and other basic needs be completed by the Provider. IEHP's Social Health Survey (Transgender Pre-Operative Assessment) can be accessed at <https://ww3.iehp.org/en/providers/special-programs/iehp-gender-health/> and click on IEHP Social Health Survey.

**C. Penile Prosthesis Requests:**

IEHP will review requests on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity. Penile prosthesis requests require:

1. Completion of genital gender-affirming surgery consultation
2. Status of phalloplasty:
  - a. Approved request for phalloplasty surgical procedure; OR
  - b. Completion of phalloplasty surgical procedure
3. Documentation of:
  - a. Inability to achieve insertive coitus; AND
  - b. Tried and failed external penile rigidity device (e.g. penile splint)

**D. Other Gender Affirming Surgical Interventions:**

**1. Facial Reconstructive Surgical Consultation:**

- a. The individual must have a diagnosis of persistent gender dysphoria.
- b. The individual must be 18 years of age or older.
- c. The individual must be able to provide informed consent;
  - i. Feminizing/Masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment.
  - ii. The treating surgeon must show that the individual has received appropriate education prior to the proposed procedure.
- d. Evidence of 12 continuous months of hormone therapy, unless medical contraindication to hormone therapy documented.
- e. Member has lived as the preferred gender for 12 continuous months.
- f. A Medical Evaluation Form is to be completed (see Attachment B).  
Alternatively, the Provider may submit the same content in the clinical documentation.
- g. The Provider or Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (see Attachment C). Alternatively, a letter from the Provider addressing the same content as Attachment C is acceptable.
  - i. The form/letter must evaluate facial feature(s) that cause persistent gender dysphoria, clarify goals and expectations, and assess self-acceptance, AND
  - ii. Address how the presence of stated feature(s) impair function in relation to activities of daily living, AND
  - iii. Address how reconstruction of said features will improve quality of life and daily function.

**2. Facial Reconstructive Surgery requests:**

- a. All components of facial reconstructive consultation requests have been completed;
- b. Clear documentation of proposed facial reconstructive procedures with evidence, to include photos, justifying medical necessity and reconstructive purpose of requested surgical procedure.
- c. Cosmetic services are not a covered benefit.

**3. Revisions of Gender-Affirming Surgery Requests:**

IEHP authorizes requests for surgical revision on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity. IEHP does not cover cosmetic surgery. Clinical documentation must support medical necessity. Surgical revision requests require:

- a. Medical and/or functional complications of prior gender affirming procedure.
- b. Measurements and/or photographs of deformity/asymmetry (if applicable).
- c. Endorsement of medical necessity from the performing surgeon.

4. It is strongly recommended that a **social health assessment** that screens the Member for social needs such as housing, food, transportation, and other basic needs be completed by the Provider prior to proceeding with all surgical interventions. IEHP's Social Health Survey (Transgender Pre-Operative Assessment) can be accessed at

<https://ww3.iehp.org/en/providers/special-programs/iehp-gender-health/> and click on IEHP Social Health Survey.

**E. Medically Necessary Durable Medical Equipment (DME) Items:**

1. The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain. Prescribed DME items may be covered as medically necessary only to preserve bodily function essential to activities of daily living or to prevent significant physical disability.
  - a. Chest binders are used by transgender men to alleviate disabling symptoms of gender dysphoria and improve activities of daily living. Chest binder use may obviate the need to proceed with gender affirming surgery. As such, chest binders are a medically necessary DME item and will be allowed with a frequency limit of 3 (three) every 6 (six) months.
  - b. Vaginal dilation protocols are a required part of the post-operative treatment plan for transgender women who have undergone vaginoplasty. As such, vaginal dilators are a medically necessary DME item in order to ensure an optimal post-operative course and are allowed one time per Member.

**F.** Please refer to *UM Subcommittee Approved Guideline Hair Removal* for hair reduction consultation and procedure authorization criteria.

**For Members under 18 years of age<sup>1</sup>:**

**A. Hormone Therapy**

1. The individual must have a diagnosis of gender dysphoria.
2. It is strongly recommended that the individual be in therapy with a mental health professional.
  - a. The mental health professional must have at a minimum a master's degree or its equivalent in a clinical behavioral science field by an accredited institution, an up-to-date clinical license, and training in childhood and adolescent developmental psychopathology.
3. Puberty-Suppressing Hormone therapy requires a referral with the following information:
  - a. Demonstration of long-lasting and intense pattern of gender non-conformity or gender dysphoria.
  - b. Gender dysphoria emerged or worsened with onset of puberty.
  - c. Coexisting psychological, medical, or social problems that could interfere with treatment have been addressed.
  - d. Informed consent has been obtained by the parent or other caretaker or guardians.
  - e. Puberty-suppression hormone therapy typically is provided at Tanner level 2 development.
4. Feminizing/Masculinizing Hormone therapy requires:
  - a. Demonstration of long-lasting and intense pattern of gender non-conformity or gender dysphoria.

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<sup>1</sup> Gender-affirming care for transgender youth is a young and rapidly evolving field. In the absence of solid evidence, Providers must rely on expert opinion. This guideline is largely based on expert opinion from the fields of adolescent medicine, pediatric endocrinology, family medicine, and advanced practice nursing who have many years of expertise in clinical care and research.

- b. Gender dysphoria emerged or worsened with onset of puberty.
  - c. Coexisting psychological, medical, or social problems that could interfere with treatment have been addressed.
  - d. 16 years of age and sufficient mental capacity to give informed consent.
    - i. Feminizing/Masculinizing Hormone therapy prior to age 16 years may be granted on a case-by-case review with medical justification that benefits outweigh the risks.
  - e. Informed consent has been obtained by the parent or other caretaker or guardians. This should include a discussion regarding options for fertility preservation.
5. The medical provider prescribing the gender-affirming hormones may be a Pediatrician or other PCP, an Endocrinologist, or another medical professional with a license to prescribe hormones.
- a. The goal of trans-feminizing hormone therapy is the development of female secondary sex characteristics, and suppression/minimization of male endogenous secondary sex characteristics.
  - b. The goal of trans-masculinizing hormone therapy is the development of male secondary sex characteristics, and suppression/minimization of female endogenous secondary sex characteristics.

**B. Gender-affirming surgical therapy for Members younger than 18 years:**

1. Genital surgery is not covered for Members younger than 18 years of age;
2. Chest surgery is covered in transgender female to male Members younger than 18 years of age based on the following criteria:
  - a. 1 year of testosterone treatment, and
  - b. Living in preferred gender for ample amount of time;
  - c. The individual must have a diagnosis of persistent gender dysphoria;
  - d. Informed consent is obtained. Feminizing/masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual/parent must have the capacity to make a fully informed decision to consent to treatment;
  - e. A Medical Evaluation Form is to be completed (see Attachment B). Alternatively, the Provider may submit the same content in the clinical documentation;
  - f. The Provider or Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (see Attachment C). Alternatively, a letter from the Provider addressing the same content as Attachment C is acceptable.
    - i. **One form/letter (for chest surgeries)** from an individual's treating Primary Care Provider or mental health professional endorsing the request in writing is required for (F to M) mastectomy with male chest reconstruction.
3. All other transgender reconstructive surgery requests for Members younger than 18 years of age will be reviewed for medical necessity on a case by case basis.
4. It is strongly recommended that a **social health assessment** that screens the Member for social needs such as housing, food, transportation, and other basic needs be completed by the Provider prior to all surgical interventions. IEHP's Social Health Survey (Transgender Pre-Operative Assessment) can be accessed at <https://ww3.iehp.org/en/providers/special-programs/iehp-gender-health/> and click on IEHP Social Health Survey.

**C. Covered Gender-Affirming Surgery (traditionally considered reconstructive in nature):**

1. Hysterectomy
2. Salpingo-oophorectomy
3. Urethorplasty
4. Metoidioplasty
5. Phalloplasty
6. Vaginectomy
7. Scrotoplasty
8. Penile Implant
9. Testicular Prosthesis
10. Penectomy
11. Orchiectomy
12. Vaginoplasty
13. Colovaginoplasty
14. Clitoroplasty
15. Vulvoplasty
16. Labiaplasty

**D. Other Commonly Requested Surgeries (that would be reviewed on a case by case basis for medical necessity):**

1. Abdominoplasty
2. Augmentation Mammoplasty
3. Face lift, Blepharoplasty
4. Brow Lift
5. Calf Implants
6. Cheek/Malar Implants
7. Chin/Nose Implant
8. Collagen injections
9. Facial Bone Reconstruction
10. Forehead Lift
11. Hair Removal or Transplant
12. Liposuction
13. Lip Reduction
14. Mastopexy
15. Neck Tightening
16. Pectoral Implants
17. Reduction Thyroid Chondroplasty
18. Removal of Redundant Skin
19. Rhinoplasty
20. Voice Therapy/Voice Lessons
21. Voice Modification Surgery

## **COVERAGE LIMITATIONS AND EXCLUSIONS**

### **Coding Issues-** CPT Codes Not Covered:

1. 55970 Intersex surgery, male to female
2. 55980 Intersex surgery, female to male
3. Due to the serial nature of surgery for the gender transition, CPT-4 coding should be specific for the procedures performed during each operation. A Treatment Authorization Request (TAR) is necessary only for procedures that currently require a TAR.

## **ADDITIONAL INFORMATION**

In the second half of the twentieth century, awareness of the phenomenon of gender dysphoria (discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth) increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria. These include:

1. Psychotherapy for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.
2. Changes in gender expression and role.
3. Hormone therapy to feminize or masculinize the body or puberty suppression therapy.
4. Surgery to change primary and/or secondary sex characteristics.

## **CLINICAL/REGULATORY RESOURCE**

### **Medi-Cal (2017):**

Treatment for gender dysphoria is a covered Medi-Cal benefit when medically necessary.

### **Department of Health Care Services, All Plan Letter 16-013 (2016):**

The purpose of this All Plan Letter (APL) is to remind Medi-Cal managed care health plans (MCPs) that they must provide covered services to all Medi-Cal beneficiaries, including transgender beneficiaries.

### **Apollo (2018):**

Either surgical or hormonal reassignment therapy must meet the Harry Benjamin International Gender Dysphoria Association criteria for gender reassignment.

### **World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7 - WPATH (2012):**

The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health.

## DEFINITION OF TERMS

Gender dysphoria: Discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth.

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12. United Healthcare. "Reimbursement Policy: Transsexual Surgery." 2014
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**DISCLAIMER**

IEHP Clinical Authorization Guidelines (CAG) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Authorization Guidelines (CAG) express IEHP's determination of whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. IEHP has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). IEHP makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Authorization Guidelines (CAG). IEHP expressly and solely reserves the right to revise the Clinical Authorization Guidelines (CAG), as clinical information changes.

## ATTACHMENT A

### Types of Genital Surgery

#### **Female to Male:**

#### **CPT Codes**

Hysterectomy, Salpingo-  
oophorectomy Reconstruction of  
urethra Metoidioplasty  
Phalloplasty Vaginectomy  
Scrotoplasty  
Implant Penile and/or Testicular prosthesis

#### **Male to Female:**

Penectomy	54125
Orchiectomy	54520, 54690
Vaginoplasty	57335
Colovaginoplasty	57291, 57292
Clitoroplasty	56805
Vulvoplasty	
Labioplasty	5899

## ATTACHMENT B

### Transgender Health Services Medical Evaluation Form

Member's current Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member's name on file with insurance, if different: \_\_\_\_\_

Hormone Therapy History                      Mark only one "Yes":

**Yes**

- This Member has taken 12 continuous months of hormone therapy as appropriate to the Member's gender goals, **OR**
- Hormone therapy is not appropriate for this Member's gender goals, **OR**
- This Member has medical contraindications to hormones therapy, **OR**
- This Member is unable or unwilling to take hormone therapy

**Please mark either "Yes" or "No" for every item on the rest of the document. All items must be completed.**

**Yes      No**

- This Member has gender dysphoria

**Medical conditions that could interfere with expected outcomes of proposed surgery**

**Yes      No**

**Yes      No**

- |                          |                          |  |                          |                          |                                      |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Uncontrolled diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | History of venous thromboembolism    |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Active infection</b>                  | <input type="checkbox"/> | <input type="checkbox"/> | <b>History of poor wound healing</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Severe immunosuppression</b>          | <input type="checkbox"/> | <input type="checkbox"/> | <b>Obesity BMI: _____</b>            |
| <input type="checkbox"/> | <input type="checkbox"/> | Other unstable medical conditions: _____ |                          |                          |                                      |

**Other Conditions**

**Yes      No**

**Yes      No**

- |                          |                          |                        |                          |                          |                                 |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco/nicotine use   | <input type="checkbox"/> | <input type="checkbox"/> | Other significant substance use |
| <input type="checkbox"/> | <input type="checkbox"/> | Cannabis/marijuana use |                          |                          |                                 |

If any medical condition present please document plans to stabilize, including a cessation plan if Member uses nicotine:

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**Yes**      **No**

- Medical conditions are well controlled
- This Member has been engaged in appropriate medical care for at least 1 year demonstrating adherence to laboratory monitoring and compliance with prescribed medications, treatments, and appointments.
- It is my opinion that the proposed surgery will benefit this Member's health

**Medical Provide Name**

**Signature**

**Date**

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Please fax form with surgical procedure referral authorization request to IEHP at (909) 890-5751.



**ATTACHMENT C**

**Provider or Therapist Documentation Form for Evaluation for Transgender Surgery**

Member's Name:

Legal Name:

DOB:

Clinician Name:

Office location or clinic:

Please describe your experience completing assessments for gender related surgeries:

\_\_\_\_\_

\_\_\_\_\_

For which surgery or surgeries are you referring this Member?

- Orchiectomy
- Penectomy
- Vaginoplasty
- Hysterectomy/Oophorectomy
- Phalloplasty
- Metoidioplasty
- Vulvoplasty/Labioplasty
- Feminizing Mammoplasty (breast augmentation)
- Subcutaneous Mastectomy with male chest reconstruction
- Surgery not listed here. Please describe:

\_\_\_\_\_

Please list the dates that you evaluated this Member for readiness and appropriateness for surgical intervention?

\_\_\_\_\_

Which current or previous medical and/or mental health providers did you speak with in your evaluation?

\_\_\_\_\_

Please give a description of this Member, identify characteristics, their history of gender dysphoria and emphasize their attempts to address their gender dysphoria:

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Please indicate the length of time the Member has taken hormones and their response to hormones?

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For Members considering Vaginoplasty, Metoidioplasty, and Phalloplasty: The Standards of Care state that the Member must have “12 continuous months of living in a gender role that is congruent with their gender identity.” Please describe how the Member has met this standard:

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Does this Member have the capacity to give informed consent for genital surgery? If no, please explain:

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Are there issues the surgeons need to know about regarding communication? These could include English fluency, hearing impairments, an autism spectrum disorder, literacy level, learning differences, etc:

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How will surgery improve this Member’s functioning? How will it make their life better? Please use the Member’s words:

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Do you have any hesitation or concern that the Member may regret or not benefit from a surgical intervention?

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Please give a brief description of this Member's mental health history, including suicidality, homicidality, and any history of violence towards healthcare workers, any psychiatric hospitalizations, and residential treatment for mental health or substance use:

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Please list all current and past mental health diagnoses:

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Please list all medications that the Member is currently taking related to psychological concerns, sleep, or emotional problems (this should include supplements, like St. John's Wort and medical marijuana). Please list the prescriber's name next to the medication:

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Does this Member have a mental health problem that the stress of surgery, anesthesia, or recovery may result in decompensation? For instance, PTSD, anxiety disorders, schizophrenia, substance abuse, etc:

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Please describe how you have prepared this Member for this possibility and how it will be addressed:

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Please describe current and past substance use including nicotine. Please list any concerns the Member has regarding their substance use or their sobriety and pain medication:

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Please describe medical problems the Member may have:

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What is your assessment of this Member's function, including their ability to satisfactorily complete ADL's and IDL's (Activities of Daily Living and Instrumental Activities of Daily Living.):

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Describe this Member's support system, relationships, family support and work:

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Do you believe this Member is capable of carrying out their aftercare plan? (Including providing for their own self-care following surgery; e.g. dilation 3x per day, hygiene issues, monitoring for infections, getting adequate nutrition, staying housed, etc.)      Yes       No

What additional care will this Member need and how will that be arranged? Who will provide needed case management?

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Your rationale for the referral for surgery:

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Is the Member's gender identity stable and consolidated?      Yes       No

Do you believe the Member has realistic expectations about what the surgery can and cannot do?

Yes       No



Is there anything you would like to add?

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Your Name, Title and License:

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Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your phone number for follow up: \_\_\_\_\_

Please print and sign this form:

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Please fax form with surgical procedure referral authorization request to IEHP at (909) 890-5751.