



# MEDICAL POLICY STATEMENT

## Georgia Medicaid

Policy Name & Number	Date Effective
Gender Affirming Surgery-GA MCD-MM-0734	01/01/2023-10/31/2023
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

### Table of Contents

A. Subject.....	2
B. Background.....	2
C. Definitions.....	2
D. Policy.....	3
E. Conditions of Coverage.....	6
F. Related Polices/Rules.....	6
G. Review/Revision History.....	6
H. References.....	7

A. Subject  
**Gender Affirming Surgery**

B. Background

Individuals with gender dysphoria have persistent feelings of gender discomfort and inappropriateness for assigned natal anatomical sex, strong and ongoing cross-gender identification, and a desire to live and be accepted as a member of the opposite sex.

The Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5, 2013) removed *Gender Identity Disorder* and established the category of *Gender Dysphoria* to reflect that gender dysphoria is no longer considered a sexual dysfunction. Clinically significant distress or impairment in social, occupational, or other important areas of functioning, in addition to the symptoms noted in DSM-5, is required to diagnose gender dysphoria. Gender nonconformity is not considered a psychiatric disorder.

There are typically three approaches utilized to alleviate or reduce the symptoms of gender dysphoria, including psychotherapy, hormonal therapy, and gender affirming surgery. Not all individuals with gender dysphoria elect all these approaches but may choose one or a combination of approaches.

C. Definitions

- **Behavioral Health Provider** - A provider of behavioral health services, including a psychologist, psychiatrist, or psychiatric nurse practitioner.
- **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)** - The standard language by which clinicians, researchers, and public health officials in the United States communicate about mental disorders and subsequent criteria and classification.
- **Female-to-Male (FtM or transmasculine)** - An adjective describing an individual born or assigned "female" at birth ("natal female") changing or changed to a more masculine body or gender role.
- **Gender Affirming Surgeon** - Board-certified urologist, gynecologist, plastic surgeon, or general surgeon competent in urological diagnosis and treatment of transgender individuals.
- **Gender Affirming Surgery** - Surgery to change primary and/or secondary sex characteristics to affirm gender identity, also referred to as intersex surgery, transgender surgery, and gender confirmation surgery in the literature and includes "top" surgery, such as mastectomy, and "genital" or "bottom" surgery, such as hysterectomy, oophorectomy, vaginectomy, metoidioplasty, and phalloplasty.
- **Gender Dysphoria** - An individual's affective and/or cognitive discontent or distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender, lasting at least six (6) months and meeting diagnostic criteria listed in the DSM 5.
- **Gender Identity** - A category of social identity referring to an individual's identification as male, female, neither, or a combination of male and female and may be different from an individual's sex assigned at birth.
- **Male-to-Female (MtF or transfeminine)** - An adjective describing an individual born or assigned "male" at birth ("natal male") changing or changed to a more feminine body or gender role.

- **Non-Binary/Gender Queer** - An adjective used to describe an individual who identifies as neither exclusively male nor female but different from gender assigned at birth, including changing to either a more masculinized or feminized gender role.
- **Sex** - Usually based on the appearance of external genitalia and defined as male or female as understood in the context of reproductive capacity, such as sex hormones, chromosomes, gonads and non-ambiguous external and internal genitalia. At times, sex is assigned when external genitalia are ambiguous.
- **Transgender (trans)** - An umbrella term for persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth.

#### D. Policy

It is the policy of CareSource to comply with state and federal regulations. CareSource treats all members consistent with his/her gender identity and does not deny or limit health services that ordinarily or exclusively are available to individuals of one sex to a transgender individual because the individual's sex or gender is different from the one to which health services are normally or exclusively available. CareSource covers those services that are medically necessary. In determining services that are medically necessary, or the coverage of health services related to gender transition, CareSource utilizes neutral standards supported by evidence-based criteria.

Members under the age of twenty-one (21) will be reviewed for medical necessity as required by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In general, CareSource considers hormonal treatment for members medically necessary. Refer to pharmacy policy "Gender-Affirming Hormone Therapy Pharmacy Policy." Due to the virtual nonexistence of research in these populations, particularly regarding long-term outcomes, safety data, and United States Institutional Review Board oversight, CareSource reviews the literature and policies annually and when new literature becomes available. Notwithstanding the foregoing, CareSource reviews each request on a case-by-case basis in accordance with medical necessity policies, as well as federal and state regulations for sterilization.

- I. CareSource considers gender affirming surgeries for transition and nonbinary members medically necessary when the following clinical criteria are met:
  - A. Breast augmentation for male to female transition is not covered. Mastectomy for female to male transition or other top surgery requests require the following:
    1. Unless there is a well-documented contraindication or refusal to take hormones, at least twelve (12) months of continuous hormone treatment is required to be considered for surgery.
      - a. Hormone trial must be with a medication prescribed to the member.
      - b. Hormones must be managed by a healthcare provider (e.g., an endocrinologist, primary care provider or experienced prescriber working in a center/clinic specializing in the treatment of gender affirming care). Evidence of lab monitoring of hormone levels must be provided.
    2. One letter of recommendation from a behavioral health provider to the surgeon is required. The behavioral health provider must communicate willingness to be available to treat the member during transition or make appropriate referral if member needs assistance with behavioral health treatment.
      - a. The behavioral health provider has evaluated the member within the past

twelve months of the time of referral.

01. If member has been in behavioral health treatment, it is preferred that the recommendation is made by the treating behavioral health provider.
02. If there is not a treating behavioral health provider, a letter of recommendation may be made by a consulting behavioral health provider.
03. If the behavioral health provider is a member of a treatment team with the surgeon, documentation in the integrated clinical record is an option in lieu of a letter.
- b. Content of the behavioral health provider referral letter must address all the following:
  01. Member has a gender dysphoria diagnosis persistent for six (6) months or longer at the time of the medical necessity review request.
  02. A member-specific treatment plan to address gender affirming treatment, including hormonal treatment and/or surgery, as well as behavioral health during this transition period.
  03. Member has capacity to and did give informed consent for surgery, as well as understanding that surgery may not achieve the desired results.
  04. Member is age 18 years or older.
  05. If co-existing mental illness and/or substance related disorder are present, it is relatively well controlled, and there has been no recent, active intravenous drug use with no suicide attempts or behaviors.
  06. The degree to which the member has followed the standards of care to date and the likelihood of future compliance.
3. Surgeon documentation requirements include all the following:
  - a. Results of medical and psychological assessment, including diagnosis (-es) and identifying characteristics.
  - b. Surgery plan.
  - c. Documentation of informed consent discussion, including:
    01. Notation of discussion of risks, benefits, and alternatives to treatment, including no hormonal or surgical treatment, and member understanding that surgery may not resolve gender dysphoria.
    02. Medical stability for surgery and anesthesia.
    03. Expected outcome(s).
- B. For genital or bottom surgery (e.g., clitoroplasty, metoidioplasty, penectomy, vaginectomy, etc.):
  1. At least twelve (12) months of continuous hormone treatment is required to be considered for surgery, unless there is a well-documented contraindication or refusal to take hormones.
    - a. A hormone trial must be with a medication prescribed by a provider.
    - b. Hormones must be managed by a healthcare provider (e.g., an endocrinologist, primary care provider or experienced prescriber working in a center/clinic specializing in the treatment of gender affirming care). Evidence of lab monitoring of hormone levels must be provided.
  2. Hair removal may be approved based on medical necessity when skin flap area contains hair needing to be removed.
  3. Two letters of recommendation from separate behavior health providers to the surgeon are required. One of the letters provided should be by a psychologist or psychiatrist, or psychiatric nurse practitioner, and one provider must

communicate willingness to be available to treat the member during transition or make appropriate referral if member needs assistance with behavioral health treatment.

- a. The behavioral health provider has evaluated the member within the past twelve months of the time of referral.
  01. If member has been in treatment, it is preferred that one of the recommendations is made by the treating behavioral health provider.
  02. If there is not a treating behavioral health provider, one letter of recommendation needs to be made from a psychologist or psychiatrist, or psychiatric nurse practitioner.
  03. If the behavioral health provider is a member of a treatment team with the surgeon, documentation in the integrated clinical record is an option in lieu of a letter.
- b. Content of referral must address all the following:
  01. Duration of evaluator's relationship with the member.
  02. Member has a gender dysphoria diagnosis persistent for six (6) months or longer at the time of the medical necessity review request.
  03. Member has capacity to and did give informed consent for surgery.
  04. A member specific treatment plan to address gender affirming treatment, including hormonal treatment and/or surgery, as well as behavioral health during this transition period.
  05. Member is age 18 years or older.
  06. Member has had a twelve (12) month or longer real-life experience congruent with their gender identity. This timeline may be modified with corroborating documentation indicating a safety concern.
  07. If co-existing mental illness and/or substance related disorder are present, it is relatively well controlled, and there has been no recent, active intravenous drug use with no suicide attempts or behaviors.
  08. The degree to which the member has followed the standards of care to date and the likelihood of future compliance.
4. Surgeon documentation requirements include all the following:
  - a. Results of medical and psychological assessment, including diagnosis (-es) and identifying characteristics.
  - b. Surgery plan.
  - c. Documentation of informed consent discussion, including:
    01. Notation of discussion of risks, benefits, and alternatives to treatment, including no treatment, and member understanding that surgery may not resolve gender dysphoria.
    02. Hair removal.
    03. Medical stability for surgery and anesthesia.
    04. Expected outcome(s).

II. The following items are not covered:

Procedures or surgeries to enhance secondary sex characteristics are considered cosmetic and are not medically necessary. A list of services, procedures or surgeries not covered is included below. This list may not be all inclusive.

1. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
2. Abdominoplasty
3. Blepharoplasty

4. Brow lift
5. Body contouring
6. Botox treatments
7. Breast augmentation
8. Calf, cheek, chin, malar, pectoral and/or nose implants
9. Collagen injections
10. Drugs for hair loss or hair growth
11. Face lifts
12. Facial bone reduction or facial feminization
13. Perineal skin hair removal
14. Hair removal for vaginoplasty without creation of neovagina or when genital surgery is not yet required or not approved
15. Hair replacement
16. Lip enhancement or reduction
17. Liposuction
18. Mastopexy
19. Neck tightening
20. Plastic surgery on eyes
21. Reduction thyroid chondroplasty
22. Rhinoplasty
23. Skin resurfacing
24. Voice modification surgery (laryngoplasty or shortening of the vocal cords), voice therapy or voice lessons
25. Any other surgeries or procedures deemed not medically necessary
26. Reproduction services including but not limited to sperm preservation, oocyte preservation, cryopreservation of embryos, surrogate parenting, donor eggs and donor sperm and host uterus.

III. CareSource treats all members consistent with gender identity and does not deny or limit health services that ordinarily or exclusively are available to individuals of one sex to a transgender individual because the individual's sex or gender is different from the one to which health services are normally or exclusively available.

Examples of such services include:

- A. Breast cancer screening for transgender men and nonbinary people who were assigned female at birth
- B. Prostate cancer screening for transgender women and nonbinary people who were assigned male at birth

E. Conditions Of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

ACTION	DATES	ACTION
Date Issued	05/18/2017	
Date Revised	05/29/2019	Updated evidence, changed policy number (MM-0080), removed pharmacy portions, added additional requirements for surgery, added

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.



	09/02/2020	specifics on hair removal, items not covered and types of surgery for medical necessary review.
	07/07/2021	Updated definitions, removed research and put in references, removed codes, updated references, changed letter recommendation requirement, and changed title.
	05/19/2022	Removed endocrinologist rule, added psychiatric NP, added safety considerations.
	01/01/2023	Annual review. Updated and added definitions. Criteria updated to MCG, 26th edition standards.
Date Effective	01/01/2023	
Date Archived	10/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

## H. References

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