MEDICAL POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Gender Affirming Surgery-OH MCD-MM-0034	12/01/2023-10/31/2024
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.

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A. Subject
Gender Affirming Surgery

B. Background
Individuals with gender dysphoria display psychological distress resulting from an incongruence between sex assigned at birth based on external genitalia and gender identity, or one's psychological sense of gender. Gender expression involves the way an individual presents his or her "self" to the world and may or may not align with gender identity. Gender affirmation can include social domains, such as changing pronouns, legal domains, such as changing one's name or gender marker's, medical domains, such as use of gender-affirming hormones, or surgical domains, including vaginoplasty or breast augmentation.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revised (DSM-R-TR), provides for one overarching diagnosis of gender dysphoria with separate criteria for children, adolescents, and adults all involving a marked incongruence between experienced/expressed gender and assigned gender with other associated criteria. Treatment varies for each individual but can include psychotherapy, hormone therapy, and/or surgical approaches. Support may also include affirmation in various domains, family and societal group support, and peer support.

C. Definitions
- **Behavioral Health Provider** - Provider of behavioral health (BH) services (minimum master's level), including a psychologist, psychiatrist, or psychiatric nurse practitioner.
- **Diagnostic and Statistical Manual of Mental Disorders, 5th Ed., Text Revised (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 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 (i.e., intersex or transgender surgery, gender reassignment or confirmation surgery) 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-TR.
- **Gender Identity** - A person's inner sense or identification as male, female, a combination of both, or neither, and may be different from sex assigned at birth.
- **Male-to-Female (MtF or transfeminine)** - 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 individual identifying as neither exclusively male nor female but different from the gender assigned at birth, including changing to 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 (i.e., 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 does not align in a traditional sense with the gender 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) years 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 medically necessary for transitioning and nonbinary members ages 18 and older when **ALL** the following clinical criteria are met:
   A. Both mastectomy for female to male surgery and breast augmentation for male to female transition require the following:
      1. hormone trial
         a. breast augmentation: 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. Hormone trial must be with a medication prescribed to the member and 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.
         b. mastectomy for female to male surgery: hormone trial not required
      2. One letter of recommendation from a behavioral health (BH) provider to the surgeon is required. The BH provider must communicate willingness to be

available to treat the member during transition or make appropriate referral if member needs assistance with BH treatment.

a. The BH provider has evaluated the member within the past 12 months of the time of referral.
   01. If member has been in BH treatment, it is preferred that the recommendation is made by the treating BH provider.
   02. If there is not a treating BH provider, a letter of recommendation may be made by a consulting BH provider.
   03. If the BH provider is on a treatment team with the surgeon, documentation in the clinical record is an option in lieu of a letter.

b. Content of the BH 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. If co-existing mental illness and/or substance related disorder are present, it is relatively well controlled, and there has been no active intravenous drug use with no recent suicide attempts or behaviors.
   05. 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/"bottom" surgery (e.g., clitoroplasty, penectomy) for members ages 18 and older:

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 hormone trial must be with a medication prescribed by a provider and managed by 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 BH 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 BH 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 BH provider.
   02. If there is not a treating BH provider, one letter of recommendation needs to be made from a psychologist or psychiatrist, or psychiatric nurse practitioner.
   03. If the BH provider is on a treatment team with the surgeon, documentation in the 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 gave informed consent for surgery.
   04. A member specific treatment plan to address treatment, including hormonal treatment and/or surgery, as well as BH during this transition period.
   05. 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.
   06. If co-existing mental illness and/or substance related disorder are present, it is relatively well controlled, and there has been no active intravenous drug use with no recent suicide attempts or behaviors.
   07. 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. 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.
   A. reversal of genital surgery or surgery to revise secondary sex characteristics
   B. abdominoplasty
   C. blepharoplasty
   D. brow lift
   E. body contouring

F. botulinum toxin treatments (i.e., Botox, Dysport, Xeomin, Jeuveau)
G. calf, cheek, chin, malar, pectoral and/or nose implants
H. collagen injections
I. drugs for hair loss or hair growth
J. face lifts
K. facial bone reduction or facial feminization
L. perineal skin hair removal
M. hair removal for vaginoplasty without creation of neovagina or when genital surgery is not yet required or not approved
N. hair replacement
O. lip enhancement or reduction
P. liposuction
Q. mastopexy
R. neck tightening
S. plastic surgery on eyes
T. reduction thyroid chondroplasty
U. rhinoplasty
V. skin resurfacing
W. voice modification surgery (laryngoplasty or shortening of the vocal cords), voice therapy or voice lessons
X. any other surgeries or procedures deemed not medically necessary
Y. 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

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 specifics on hair removal, items not covered and types of surgery for medical necessary review.
	09/02/2020	Updated definitions, removed research and put in references, removed codes, updated references, changed letter recommendation requirement, and changed title.

	07/07/2021 05/19/2022 6/21/2023	Removed endocrinologist rule, added psychiatric NP, added safety considerations. Annual review. Updated and added definitions. Added primary care provider to hormone therapy requirement. Removed conception counseling as requirement for bottom surgery. Removed breast augmentation from the exclusion list. Annual review. Updated background, definitions, and reference list. Approved at Committee.
Date Effective	12/01/2023	
Date Archived	10/31/2024	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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