

# Transgender Services: Clinical Criteria and Policy

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*UMP members should refer to Regence medical policy 153 for information about UMP's coverage of transgender services, with the exception of information in the "Medical Policy Criteria" box in policy 153. Instead of the criteria listed in that box, the UMP-specific clinical criteria outlined below must be met to receive gender reassignment surgical services.*

## I. Medical Treatments for Gender Dysphoria

- A. Psychotherapy may be considered medically necessary as a treatment of gender dysphoria.
- B. Continuous hormone therapy may be considered medically necessary as a treatment of gender dysphoria when all of the following criteria are met:
  - 1. Clinical records document that the patient has the capacity to make fully informed decisions and consent for treatment; and hormone therapy is part of a comprehensive, patient-centered treatment plan; and
  - 2. A licensed behavioral health practitioner or a licensed physician, advanced registered nurse practitioner (ARNP), physician's assistant (PA) or psychologist is treating the patient for primary care or transgender services and:
    - a) Assesses the patient and makes or confirms the diagnosis of gender dysphoria as defined by the DSM-V criteria, and
    - b) Determines or confirms that the gender dysphoria is not due to another mental or physical health condition.
  - 3. Providers diagnosing and treating patients for medical treatment for gender dysphoria must document these minimum credentials and competencies as part of a comprehensive, patient-centered treatment plan:
    - a) Meet the requirements of professional licensure and practice according to the scope of practice for their licensure.
    - b) Attest to specialized competencies in managing hormone therapy for persons diagnosed with gender dysphoria which may include documented, supervised training or mentoring with a more experienced physician.
    - c) Be knowledgeable of and practice the standards of care for the health of transsexual, transgender, and gender-nonconforming people as developed by the World Professional Association for Transgender Health (WPATH).

## II. Surgical Treatments of Gender Dysphoria

- A. Gender reassignment surgery (see UMP clinical criteria policy and Regence medical policy 153 guidelines) 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 mastectomy 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 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 sections 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-male patients.
    - 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-male patients.
  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.
- B. Prior authorization is required for all proposed surgical interventions. Section II.A of this policy lists the requirements and documentation that must be submitted for prior authorization review. Surgeries are not required to be completed at the same time and,

instead, may be performed and receive prior authorization in progressive stages. UMP covers the following procedures with prior authorization that meet medical necessity criteria:

1. Blepharoplasty: covered only if restorative function medical criteria are met (not specific to transgender surgery);
  2. Breast reconstruction (male-to-female patients) will require preauthorization with following criteria:
    - a) Documentation of continuous hormonal therapy for at least 12 months, unless there is a documented contraindication to hormonal therapy; AND
    - b) Documentation from surgeon of current cup size and proposed changes as well as photo documentation; AND
    - c) No measurable cup size growth, defined as less than an A cup, in one or both breasts; OR
    - d) Asymmetry where one breast did not have a measurable cup size growth, defined as less than an A cup. (Example: Client presents with response with one breast B cup and one breast A cup = Non-covered; Client presents with response with one breast B cup and one breast with no measurable cup size =covered.)
  3. Bilateral mastectomy with or without chest reconstruction;
  4. Cliteroplasty;
  5. Colovaginoplasty;
  6. Colpectomy;
  7. Genital surgery;
  8. Genital electrolysis as required as part of the genital surgery is covered with prior authorization and is limited to the genitals and, if applicable, the graft site, as required for genital surgery. Electrolysis not meeting these guidelines and the guidelines for Surgical Treatments of Gender Dysphoria outlined in the Transgender Services Clinical Criteria and Policy is not covered.
  9. Hysterectomy;
  10. Labiaplasty;
  11. Laryngoplasty;
  12. Metoidioplasty;
  13. Orchiectomy;
  14. Penectomy;
  15. Phalloplasty;
  16. Placement of testicular prosthesis;
  17. Rhinoplasty: covered only if restorative function medical criteria are met (not specific to transgender surgery);
  18. Salpingo-oophorectomy;
  19. Scrotoplasty;
  20. Urethroplasty;
  21. Vaginectomy; and
  22. Vaginoplasty.
- C. Other than gender reassignment surgeries listed in this policy, surgery and/or additional treatments to change specific appearance characteristics are considered not medically necessary as treatments of gender dysphoria, including, but not limited to the following:
1. Abdominoplasty;
  2. Brow lifts;
  3. Calf implants;
  4. Cheek/malar implants;
  5. Chin/nose implants;
  6. Collagen injections;
  7. Drugs for hair loss or growth;
  8. Facial or trunk electrolysis;
  9. Facial feminization;

10. Face lift;
11. Forehead lift;
12. Hair transplantation;
13. Jaw shortening;
14. Lip reduction;
15. Liposuction;
16. Mastopexy;
17. Neck tightening;
18. Pectoral implants;
19. Reduction thyroid chondroplasty;
20. Removal of redundant skin;
21. Suction-assisted lipoplasty of the waist;
22. Trachea shave;
23. Voice modification surgery; and
24. Voice therapy/lessons.