



# Gender Affirming Interventions for Gender Dysphoria: 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 transgender 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.

## 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 a medically necessary 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; and
  - 3. At least 2 licensed mental health professionals have diagnosed gender dysphoria, and recommend surgical treatment (\*Only one mental health professional referral is required for mastectomy); 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; and

4. Documentation of continuous hormonal therapy for at least 12 months, unless there is a documented medical contraindication to hormonal therapy. Hormonal therapy is not required prior to mastectomy; and
  5. Twelve months of living in a gender role that is congruent with the patient's gender identity.
- 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 augmentation will require preauthorization with following criteria:
    - a) Documentation of continuous hormonal therapy for at least 12 months, unless there is documented medical contraindication to hormonal therapy; and
    - b) Have not reached a Tanner Stage 5.
  3. Bilateral mastectomy with or without chest reconstruction;
  4. Clitoroplasty;
  5. Colovaginoplasty;
  6. Colpectomy;
  7. Genital surgery;
  8. Genital electrolysis and laser hair removal 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 and laser hair removal not meeting these guidelines and the guidelines for Surgical Treatments of Gender Dysphoria outlined in the Gender Affirming Interventions for Gender Dysphoria Criteria and Policy is not covered.
  9. Hysterectomy;
  10. Labiaplasty;
  11. Metoidioplasty;
  12. Orchiectomy;
  13. Penectomy;
  14. Phalloplasty;
  15. Placement of testicular prosthesis;
  16. Rhinoplasty, covered only if restorative function medical criteria are met (not specific to transgender surgery);
  17. Salpingo-oophorectomy;
  18. Scrotoplasty;
  19. Urethroplasty;
  20. Vaginectomy; and
  21. 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. Brow lifts;
  2. Calf implants;
  3. Cheek/malar implants;
  4. Chin/nose implants;
  5. Chondrolaryngoplasty;
  6. Collagen injections;

7. Drugs for hair loss or growth;
8. Facial or trunk hair removal via laser or 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.

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