

## Gender Confirming Surgery

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Developed By: Medical Necessity Criteria Committee

**\*Please refer to the member handbook for the specific plan benefit. Member handbook language takes precedence over Moda Health medical necessity criteria.**

### I. Description

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Gender nonconformity refers to the extent to which a person's gender identity or expression differs from the cultural norms prescribed for people of a particular gender. Only some gender-nonconforming people experience gender dysphoria at some point in their lives.

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder.

#### The current DSM 5 criteria for gender dysphoria include:

- A. A marked incongruence between one's experience/expressed gender and assigned gender of at least 6 months duration, as manifested by 2 or more of the following indicators:
  - a. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristic (or, in young adolescents, the anticipated secondary sex characteristics)
  - b. A strong desire to be rid of one's primary or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
  - c. A strong desire for the primary and/or secondary sex characteristics of the other gender (or some alternative gender different from one's assigned gender)
  - d. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
  - e. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability.

Treatment of severe, persistent gender dysphoria includes a variety of therapeutic options. The number and type of interventions applied and the order in which they take place may differ from person to person. Treatment options include changes in gender expression and role, hormone therapy to feminize or masculinize the body, surgery to change primary and/or secondary sex characteristics, and psychotherapy for purposes such as exploring gender identity which may include individual, couple, family, or group psychotherapy.

Gender confirming surgery is not one procedure but a complex process that involves multiple steps over a period of time with careful psychological and medical evaluations prior to initiation of each modality of treatment. It is a multidisciplinary process involving psychological, medical and surgical treatments all performed in conjunction with each other to assist the individual to achieve the desired successful outcome.

For male to female gender confirmation, surgical procedures may include genital reconstruction (vaginoplasty, penectomy, orchidectomy, clitoroplasty) and cosmetic surgery (breast implants, facial reshaping, rhinoplasty, abdominoplasty, thyroid chondroplasty [laryngeal shaving]), voice modification surgery (vocal cord shortening), hair transplants. For female to male gender confirmation, surgical procedures may include mastectomy, genital reconstruction (phalloplasty, genitoplasty, hysterectomy, bilateral oophorectomy), and cosmetic procedures to enhance male features such as pectoral implants and chest wall recontouring.

Early treatment of children and adolescents expressing long lasting distress with their assigned gender and sex characteristics with puberty-suppressing hormones followed by feminizing and masculinizing hormone therapy has been shown to avert negative social and emotional consequences more effectively than later use.

## II. Criteria: CWQI HCS-0145

- A. Psychological therapy is considered medically necessary with **ALL** of the following: (*Appendix A*)
  - a. Mental health professional providing treatment is experienced with diagnosis and treatment of gender dysphoria
  - b. Health professional has a master's degree or higher in a clinical behavioral science field
  - c. Member has expressed discomfort with assigned gender and desire to explore treatment options
  - d. Member and licensed behavioral health professional are able to screen/identify and treat co-existing mental health concerns
  - e. For treatment extending beyond one year, please refer to *Long-Term Psychotherapy Medical Necessity Criteria*

- B. Hormone therapy is considered medically appropriate with **ALL** of the following:
  - a. Referral from licensed behavioral/mental health professional who has performed assessment and r feminizing/masculinizing hormone therapy
  - b. Persistent, well-documented gender dysphoria
  - c. Capacity to make a fully informed decision and to consent for treatment
  - d. Age of majority (18 years of age or older)
  - e. If significant medical or mental health concerns are present, they must be reasonably well-controlled.
- C. Breast/chest surgery for Female-to-Male (FtM) members is medically appropriate with **ALL** of the following: (Hormone therapy is not a prerequisite)
  - a. One referral from qualified behavioral/mental health professional (See Appendix B for referral letter requirements)
  - b. Persistent, well-documented gender dysphoria
  - c. Age of majority (18 years of age or older)
  - d. If significant medical or mental health concerns are present, they must be reasonably well controlled
- D. Breast/chest surgery for Male-to-Female (MtF) members is medically appropriate with **ALL** of the following: (Hormone therapy is not a prerequisite)
  - a. One referral from qualified behavioral/mental health professional (See Appendix B for referral letter requirements)
  - b. Persistent, well-documented gender dysphoria
  - c. Age of majority (18 years of age or older)
  - d. If significant medical or mental health concerns are present, they must be reasonably well controlled.
- E. Gonadectomy (hysterectomy/oophorectomy for Female-to-Male (FtM) members or orchiectomy for Male-to-Female (MtF) members is considered medically appropriate with **ALL** of the following:
  - a. Two referrals from qualified behavioral/mental health professionals
  - b. Persistent, well documented gender dysphoria
  - c. Capacity to make a fully informed decision and to consent for treatment
  - d. Age of majority (18 years of age or older)
  - e. If significant medical or mental health concerns are present, they must be well controlled
  - f. 12 continuous months of hormone therapy as appropriate to the member’s gender goals (unless hormones are not clinically indicated for the individual)
- F. Gender confirmation surgery (metoidioplasty or phalloplasty in FtM members and vaginoplasty for MtF members) is considered medically appropriate for **ALL** of the following:
  - a. Two referrals from licensed behavioral/mental health professionals (see Attachment A)
  - b. Persistent, well-documented gender dysphoria
  - c. Capacity to make a fully informed decision and to consent for treatment
  - d. Age of majority (18 years of age or older)
  - e. If significant medical or mental health concerns are present, they must be well controlled
  - f. 12 months of continuous hormone therapy as appropriate to the member’s gender goals (unless hormones are not clinically indicated for the individual).
  - g. 12 continuous months of living in a gender role that is congruent with the member’s identity

G. Gender Confirming Facial Procedures

- a. Gender confirming facial procedures are considered medically appropriate when **ALL** the following are met:
1. Two referrals from licensed behavioral/mental health professionals (see Attachment A)
  2. Persistent, well-documented gender dysphoria
  3. Capacity to make a fully informed decision and to consent for treatment
  4. Age of majority (18 years of age or older)
  5. If significant medical or mental health concerns are present, they must be well controlled
  6. 12 months of continuous hormone therapy as appropriate to the member's gender goals (unless hormones are not clinically indicated for the individual).
  7. 12 continuous months of living in a gender role that is congruent with the member's identity

The list of gender confirming procedures that would be considered are:

- i. Tracheal Shave
- ii. Facial hair removal
- iii. Rhinoplasty/Septoplasty
- iv. Jaw Contouring
- v. Chin Contouring
- vi. Forehead Contouring
- vii. Browlift/Ptosis Repair
- viii. Cheek/Chin Implants
- ix. Blepharoplasty
- x. Hairline Advancement/Correction

H. Treatment of the Adolescent with gender dysphoria may be considered medically appropriate with **ALL** of the following:

- a. Psychological assessment of children or adolescents who present with gender dysphoria includes ALL of the following:
- i. Assessment and guidance is provided by a qualified mental health professional trained in childhood and adolescent psychopathology and competence in diagnosing in a multidisciplinary setting or in consultation with a pediatric endocrinologist (*See Appendix C*)
  - ii. Provides family counseling and supportive psychotherapy to assist the child or adolescent with exploring their gender identity
  - iii. Assess and treat any coexisting mental health concerns of children and adolescents and address them as part of the overall treatment plan
  - iv. Refer adolescents for additional physical interventions (such as puberty-suppressing hormones) with the appropriate documentation of assessment of gender dysphoria and mental health
  - v. Ability to educate and advocate on behalf of the gender dysphoric child, adolescent, and their family in their community
  - vi. Provide information and referral for peer support and support groups for parents of gender-nonconforming and transgender children

- b. Reversible therapy with puberty-suppressing hormones are medically appropriate with **ALL** of the following:
  - i. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed)
  - ii. Gender dysphoria emerged or worsened with the onset of puberty
  - iii. The member has experienced the onset of puberty to at least Tanner Stage 2
  - iv. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g. may compromise adherence with treatment) have been addressed such that the adolescent's situation and functioning are stable enough to start treatment
  - v. The adolescent has given informed consent, and particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process
- c. Partially reversible interventions with feminizing/masculinizing hormone therapy is medically appropriate with **ALL** of the following:
  - i. The adolescent has demonstrated a long lasting and intense pattern of gender non-conformity or gender dysphoria
  - ii. The adolescent has been referred by a qualified mental health professional or has been undergoing treatment with a pediatric endocrinologist for puberty-suppressing hormones
  - iii. The adolescent has given informed consent if the age of medical consent and particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process
  - iv. The adolescent has been compliant with puberty-suppressing hormone therapy
  - v. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g. may compromise adherence with treatment) have been addressed such that the adolescent's situation and functioning are stable enough to start treatment
- d. Genital surgery including gonadectomy and gender reassignment surgery (metoidioplasty or phalloplasty in FtM members and vaginoplasty in MtF members) is **NOT** covered for children or adolescents age 17 years of age or younger
- e. Chest surgery in FtM adolescent members may be carried out prior to 18 years of age with **ALL** of the following:
  - i. Meets all of the criteria for treatment of adolescent with puberty-suppressing hormones and masculinizing hormones
  - ii. Reached the age of medical consent
  - iii. Had ample time (preferably one year) living in the desired gender role
  - iv. Undergone one year of testosterone treatment.
- I. The following adjunct procedures are considered medically necessary if the specific criteria are met for the procedure requested:
  - a. Blepharoplasty
  - b. Hair removal for surgical reconstruction (i.e. genital hair removal) that meets **ALL** of the following criteria:

- i. Requested hair removal is prior to genital surgery involving hair-bearing flaps associated with vaginoplasty or phalloplasty due to **1 or more** of the following:
    - 1. Skin area will be brought into contact with urine (used to construct a neourethra)
    - 2. Skin area to be moved to reside within a partially closed cavity within the body (e.g. used to line the neovagina)
  - ii. Request is NOT for hair-bearing skin that remains outside of the body after gender confirmation surgery (metoidioplasty or phalloplasty in FtM members and vaginoplasty for MtF members) as that does not need to be removed and will NOT be covered
  - iii. Hair removal will involve **1 or more** of the following modalities which may take up to a year prior to surgery:
    - 1. Electrolysis
    - 2. Laser hair removal
  - iv. Request is NOT for hair removal for cosmetic reasons as that is NOT a covered benefit
  - v. Patient meets criteria for genital surgery in section F or gender confirming facial procedures in section G.
- c. Breast augmentation procedures
  - d. Voice therapy/voice modification
  - e. Removal of redundant skin (i.e. Panniculectomy)
- J. The following procedures are considered not medically necessary for all conditions:
- a. Abdominoplasty (tummy tuck)
  - b. Calf Implants
  - c. Liposuction
  - d. Mastopexy
  - e. Neck tightening
  - f. Removal of redundant skin other than abdominal
  - g. Skin resurfacing
- K. The following services may be excluded or limited under the member's benefit plan. Please check the member plan handbook for services related to:
- a. Infertility services/cryopreservation of sperm or embryos
  - b. Orthognathic services for jaw reconstruction
  - c. Gender Confirming Facial Procedures
- L. Reversal, revision, or removal of gender confirmation surgery is **NOT** covered. Medical or surgical complications may be covered if determined to be medically necessary to stabilize even if the original surgery was not a covered benefit.

### III. Information Submitted with the Prior Authorization Request:

- 1. Documentation of appropriate assessment of gender dysphoria diagnosis
- 2. Referral letters as appropriate for the requested procedure
- 3. Documentation of prior mental and behavioral therapies required for gender confirmation treatment

#### IV. CPT or HCPC codes covered:

| Codes   | Description  |
|---|--|
| <b>Breast/Chest Surgery Female to Male (FtM)</b>  |  |
| 15771   | Grafting of autologous fat harvested by liposuction  |
| 15772   | Grafting of autologous fat harvested by liposuction and each additional 50 cc injectate, or part thereof                                     |
| 19301   | Mastectomy, partial (eg Lumpectomy, tylectomy, quadrantectomy, segmentectomy)  |
| 19302   | Mastectomy, partial (eg Lumpectomy, tylectomy, quadrantectomy, segmentectomy) with axillary lymphadenectomy                                  |
| 19303   | Mastectomy, simple, complete   |
| 19305   | Mastectomy, radical, including pectoral muscles, axillary lymph nodes  |
| 19306   | Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)                            |
| 19307   | Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle |
| 19316   | Mastopexy  |
| 19318   | Breast reduction   |
| 19325   | Breast augmentation with implant   |
| 19340   | Insertion of breast implant on same day of mastectomy (ie, immediate)  |
| 19342   | Insertion of breast implant on separate day of mastectomy  |
| 19350   | Nipple/areola reconstruction   |
| <b>Gonadectomy FtM and MtF</b>  |  |
| 58150, 58180, 58260<br>58262, 58263, 58267<br>58270, 58275, 58280<br>58285, 58290, 58291<br>58292, 58293, 58294 | Total abdominal or vaginal hysterectomy w or w/o removal of tubes, and/or ovary(s)   |
| 58541, 58542, 58543<br>58544, 58548, 58550<br>58552, 58553, 58554   | Laparoscopic or supracervical hysterectomy w or w/o removal of tubes   |
| 58570, 58571, 58572,<br>58573   | Laparoscopic total hysterectomy w or w/o removal of tubes  |
| 58720   | Salpingo-oophorectomy  |
| 54520   | Orchiectomy  |
| 54690   | Laparoscopic orchiectomy   |
| <b>Gender Confirmation Surgery</b>  |  |
| 55970   | Intersex surgery male to female (disorders of sex development i.e. ambiguous genitalia)  |
| 55980   | Intersex surgery female to male (disorder of sex development i.e. ambiguous genitalia)   |

|   |   |
|---|---|
| 54400, 54401, 54405, 54408, 54410, 54411, 54415, 54416, 54417 | Insertion/repair/removal of penile prosthesis                           |
| 54660   | Insertion of testicular prosthesis (separate procedure)                 |
| 55175   | Scrotoplasty; simple  |
| 55180   | Scrotoplasty; complicated   |
| 56625   | Vulvectomy simple; complete   |
| 56800   | Plastic repair of introitus   |
| 56805   | Clitoroplasty   |
| 56810   | Perineoplasty, repair of perineum, non-obstetrical (separate procedure) |
| 57106, 57107  | Vaginectomy, partial removal of vaginal wall                            |
| 57110, 57111  | Vaginectomy, complete removal of vaginal wall                           |
| 57291, 57292  | Construction of artificial vagina                                       |
| 57335   | Vaginoplasty for intersex state   |
| 17380   | Electrolysis epilation, each 30 minutes                                 |
| <b>Facial Region: Upper Face</b>                              |   |
| 14020, 14021, 14301, 14302                                    | Adjacent tissue transfer, forehead (galeal advancement)                 |
| 21137   | Forehead contouring (reduction only)                                    |
| 21139   | Forehead, anterior frontal sinus wall setback                           |
| 21208   | Augmentation osteoplasty  |
| 21209   | Reduction osteoplasty (orbital reshaping)                               |
| 67900   | Repair of brow ptosis (secondary, after forehead reduction)             |
| <b>Facial Region: Mid-Face</b>                                |   |
| 14060, 14061  | Adjacent tissue transfer, lip   |
| 20912   | Septal cartilage grafts   |
| 21025   | Excision of mandibular bone   |
| 21188   | Midface reconstruction with osteotomies and bone grafts                 |
| 21141, 21142, 21143, 21145, 21146, 21147                      | LeFort I midface reconstruction   |
| 21208   | Augmentation osteoplasty  |
| 21209   | Reduction osteoplasty   |
| 21270   | Malar augmentation (alloplastic)  |
| 30400, 30410, 30420, 30430, 30450, 30460                      | Rhinoplasty (primary or secondary)                                      |
| 30465   | Vestibular stenosis repair  |
| 30520   | Septoplasty   |
| 15825, 15828, 15829   | Rhytidectomy; platysmal tightening (secondary, after jaw reduction) *   |
| <b>Face Region: Lower Face</b>                                |   |
| 21025   | Excision of mandibular bone   |
| 21120   | Augmentation genioplasty  |



|                               |   |
|-------------------------------|---|
| 21121, 21122, 21123           | Sliding genioplasty   |
| 21193, 21194, 21195,<br>21196 | Mandibular rami reconstruction  |
| 21208                         | Augmentation osteoplasty  |
| 21209                         | Reduction osteoplasty   |
| 31750                         | Cervical tracheoplasty (thyroid cartilage reduction)  |
| 21299                         | Unlisted craniofacial and maxillofacial procedure   |
| <b>Additional codes</b>       |   |
| 14040                         | Adjacent tissue transfer or rearrangement   |
| 15773, 15774,                 | Grafting of autologous fat  |
| 30410                         | Rhinoplasty, complete, external parts including bony pyramid, lateral and alar cartilages and/or elevation of the nasal tip |
| 30420                         | Rhinoplasty, including major septal repair  |

#### V. Codes when other criteria are used (see specific criteria):

| Codes | Description   |
|-------|---|
| 15822 | Blepharoplasty, upper lid   |
| 15830 | Panniculectomy  |
| 15771 | Grafting of autologous fat harvested by liposuction   |
| 15772 | + each additional 50 cc injectate, or part thereof  |
| 19325 | Breast augmentation with implant  |
| 92507 | Treatment of evaluation of speech, language, voice, communication and/or auditory processing disorder |

#### VI. Annual Review History

| Review Date | Revisions  | Effective Date |
|-------------|--|----------------|
| 11/2014     | New Medical Necessity Criteria   | 01/01/2015     |
| 12/2015     | Annual Review:   | 12/2/2015      |
| 07/2016     | Revised wording in Section VII, VIII, and IX to reflect new OR state requirements.                             | 07/27/2016     |
| 10/2016     | Added criteria in section VII.b for genital hair removal criteria, remove voice therapy guideline              | 1/25/2016      |
| 02/2018     | Annual Review: Updated to new template, revised wording  | 03/28/2018     |
| 10/2018     | Annual review: added criteria for male to female breast/chest surgery  | 10/28/2018     |
| 12/2018     | Revised wording, CPT 17380 covered under this criteria, updated codes, updated reference to Medicare guideline | 01/01/2019     |
| 05/2019     | Annual review: Duplicate language deleted from the adolescent criteria   | 06/01/2019     |
| 07/2019     | Update: Added missing items to section II.E for the criteria to meet WPATH Standards of Care                   | 08/01/2019     |
| 11/2019     | Update: CPT 19350 covered under this criteria  | 11/18/2019     |

|         |   |            |
|---------|---|------------|
| 05/2020 | Annual Review: No content changes   | 06/01/2020 |
| 09/2020 | Update: Title updated from “Gender Reassignment Surgery” to “Gender Confirming Surgery”. Added Section G; - Guidelines for Gender Confirming Facial Procedures. Added related CPT codes. Updated procedures considered experimental and investigational | 10/1/2020  |
| 01/2021 | New 2021 cpt codes 15771, 15772 replaced deleted code 19324<br>Other added CPT codes 19340, 19342; description updated for CPT codes 19318, 19325   |            |
| 09/2021 | Annual Review: No changes   | 10/01/2021 |
| 08/2022 | Annual Review: No changes   | 09/01/2022 |

## VII. References

1. Coleman, E., Bockting, W., Botzer, M., Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, International Journal of Transgenderism, 13:165–232, 2011 Copyright C \_ World Professional Association for Transgender Health
2. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2009 Sep;94(9):3132-54
3. Smits, Ariel MD, MPH; HERC Decision 20140819, Health Evidence Review Commission, Oregon Health Authority
4. *American Psychologist*: American Psychological Association. (2015): Guidelines for Psychological Practice with Transgender and Gender Nonconforming People Adopted by the Council of Representatives, August 5 & 7, 2015
5. Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)
6. Day P. (2002). Trans-gender reassignment surgery. NZHTA Tech Brief Series. Christchurch, New Zealand: New Zealand Health Technology Assessment (NZHTA); 2002;1(1). Available at: [http://nzhta.chmeds.ac.nz/publications/trans\\_gender.pdf](http://nzhta.chmeds.ac.nz/publications/trans_gender.pdf). Accessed June 30, 2010.

## Appendix 1 – Applicable Diagnosis Codes:

| Codes  | Description  |
|--------|--|
| F64.0  | Transsexualism: Gender identity disorder in adolescence and adulthood; Gender dysphoria in adolescence and adulthood |
| F64.1  | Dual role transvestism (use additional code for identity sex reassignment status)                                    |
| F64.2  | Gender identity disorder of childhood  |
| F64.8  | Other gender identity disorders  |
| F64.9  | Gender identity disorder, unspecified  |
| Z87.89 | Personal history of sex reassignment   |

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD):

| Jurisdiction(s): 5, 8   | NCD/LCD Document (s): 140.9 |
|---|-----------------------------|
| Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)   |                             |
| <a href="https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282&amp;DocID=CAG-00446N&amp;NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&amp;kq=true&amp;SearchType=Advanced&amp;bc=IAAAABAAQAAA&amp;">https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282&amp;DocID=CAG-00446N&amp;NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&amp;kq=true&amp;SearchType=Advanced&amp;bc=IAAAABAAQAAA&amp;</a> |                             |

| NCD/LCD Document (s):   |
|---|
| <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017downloads/R194NCD.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017downloads/R194NCD.pdf</a> |

| Medicare Part B Administrative Contractor (MAC) Jurisdictions |  |                                    |
|---|--|------------------------------------|
| Jurisdiction  | Applicable State/US Territory          | Contractor                         |
| F (2 & 3)   | AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ | Noridian Healthcare Solutions, LLC |

## **Appendix A**

### **Qualification/Competency for Behavioral/Mental Health Professionals Working with Adults who present with Gender Dysphoria (1)**

1. A master's degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent in the United States.
2. Competence in using the Diagnostic Statistical Manual for Mental Disorders and/or the International Classification of Diseases for diagnostic purposes
3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria
4. Documented supervised training and competence in psychotherapy and counseling
5. Knowledge about gender-nonconforming identities and expression, and the assessment and treatment of gender dysphoria
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

## **Appendix B**

### **Referral Letter Requirements for Surgery (1)**

1. The patient's general identifying characteristics
2. Results of the patient's psychosocial assessment, including diagnoses
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date
4. An explanation the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery
5. A statement that informed consent has been obtained from the patient
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

## **Appendix C**

### **Qualifications/Competency for Behavioral/Mental Health Professional treating Children and Adolescents (1)**

1. Meet the competency requirements for mental health professionals working with adults as outlined in Appendix A
2. Trained in childhood and adolescent developmental psychopathology
3. Competent in diagnosing and treating the ordinary problems of children and adolescents