Gender reassignment surgery may be a plan exclusion. Please refer to the member handbook for the specific plan benefit. Member handbook language takes precedence over Moda Health medical necessity criteria.

**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 sex. 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 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 from the one’s assigned gender)
   d. A strong desire to be treated as the other gender (or some alternative gender 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 explore gender identity which may include individual, couple, family, or group.

Gender reassignment 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.

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.

Criteria: CWQI: HCS-0145

I. 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 which may include depression, anxiety, self-harm, substance abuse, sexual concerns, personality disorders, psychotic disorders, and autistic spectrum disorders.
   e. For treatment extending beyond one year, please refer to Long Term Psychotherapy Medical Necessity Criteria

II. Hormone therapy is considered medically appropriate for ALL of the following:
   a. Referral from licensed behavioral/mental health professional who has performed assessment and recommending 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.

III. 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.

IV. Gonadectomy (hysterectomy/oophorectomy for Female-to-Male (FtM) or orchectomy for Male-to-Female (MtF) 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. Age of majority (18 years or older)
   d. 12 continuous months of hormone therapy as appropriate to the member’s gender goals
      (unless hormones are not clinically indicated for the individual)

V. Gender reassignment surgery (metoidioplasty or phalloplasty in FtM and vaginoplasty for MtF) 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

VI. 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 competent 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 nonconformity 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** is **NOT** covered for **adolescents** including **ALL** of the following:
   i. Genital surgery should not be carried out until the adolescent reaches the age of majority (18 years of age or older)
   ii. Has lived continuously for at least 12 months in the gender role that is congruent with their gender identity
   iii. Meets the additional criteria for surgical procedures for adults with gender dysphoria.

e. **Chest surgery in FtM adolescent** patients may be carried out prior to 18 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.
VII. The following adjunct procedures are considered medically necessary if the specific criteria is 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 male to female genital surgery involving hair-bearing flabs associated with vaginoplasty 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 GAS 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 must be approved for genital surgery and meet criteria b. i.-iv. Above prior to approval of hair removal
   c. Breast augmentation procedures
   d. Voice therapy/voice modification
   e. Removal of redundant skin (i.e. Panniculectomy)

VIII. The following procedures are considered not medically necessary for all conditions:
   a. Abdominoplasty (tummy tuck)
   b. Calf implants
   c. Chin/nose implants
   d. Collagen injections
   e. Face/forehead lift
   f. Brow lift
   g. Cheek implants
   h. Facial hair removal/hair transplantation
   i. Facial sculpturing/facial bone reduction
   j. Laryngoplasty
   k. Lip reduction/enhancement
   l. Liposuction
   m. Mastopexy
   n. Neck tightening
   o. Removal of redundant skin other than abdominal
   p. Rhinoplasty
   q. Skin resurfacing
   r. Trachea shave/reduction thyroid chondroplasty
IX. 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

X. Reversal, revision, or removal of gender reassignment 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.

**Information to be Submitted with Pre-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 reassignment treatment

**Applicable CPT Codes:**

<table>
<thead>
<tr>
<th>CPT/HCPC codes</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Breast/Chest Surgery Female to Male</strong></td>
<td></td>
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<tr>
<td>19301-19304</td>
<td>Mastectomy</td>
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<td>19318</td>
<td>Reduction mammoplasty</td>
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<tr>
<td><strong>Gonadectomy FtM and MtF</strong></td>
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</tr>
<tr>
<td>58150, 58180, 58260-58262, 58275-58291</td>
<td>Total abdominal or vaginal hysterectomy w or w/o removal of tubes</td>
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<tr>
<td>58541-58544, 58550-58554</td>
<td>Laparoscopic or supracervical hysterectomy w or w/o removal of tubes</td>
</tr>
<tr>
<td>58570-58573</td>
<td>Laparoscopic total hysterectomy w or w/o removal of tubes</td>
</tr>
<tr>
<td>58720</td>
<td>Salpingo-oopherectomy</td>
</tr>
<tr>
<td>54520</td>
<td>Orchietectomy</td>
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<tr>
<td>54690</td>
<td>Laparoscopic orchiectomy</td>
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<tr>
<td><strong>Gender Reassignment Surgery</strong></td>
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<tr>
<td>55970</td>
<td>Intersex surgery male to female (global includes penile amputation, vaginoplasty, clitoroplasty)</td>
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<tr>
<td>55980</td>
<td>Intersex surgery female to male (global includes phalloplasty or metoidioplasty, scrotoplasty)</td>
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<tr>
<td>54400-54417</td>
<td>Insertion/repair/removal of penile prosthesis</td>
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<tr>
<td>54660</td>
<td>Insertion of testicular prosthesis (separate procedure)</td>
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<td>56625</td>
<td>Vulvectomy simple; complete</td>
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<td>56800</td>
<td>Plastic repair of introitus</td>
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<td>56805</td>
<td>Clitoroplasty for intersex state</td>
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<td>Perineoplasty, repair of perineum, nonobstetrical</td>
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<td>57106-57107</td>
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<td>57110-57111</td>
<td>Vaginectomy, complete removal of vaginal wall</td>
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Codes Reviewed for Medical Necessity:

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<th>Description</th>
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<tr>
<td>15822</td>
<td>Blepharoplasty, upper lid</td>
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<tr>
<td>15380</td>
<td>Panniculectomy</td>
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<tr>
<td>19324</td>
<td>Mammaplasty, augmentation without prosthetic implant</td>
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<tr>
<td>19325</td>
<td>Mammaplasty, augmentation with prosthetic implant</td>
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<tr>
<td>92506</td>
<td>Evaluation of speech, language, voice, communication and/or auditory processing</td>
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<tr>
<td>92507</td>
<td>Treatment of evaluation of speech, language, voice, communication and/or auditory processing disorder</td>
</tr>
<tr>
<td>17380</td>
<td>Electrolysis epilation, each ½ hour</td>
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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     |

References:

3. Smits, Ariel MD, MPH; HERC Decision 20140819, Health Evidence Review Commission, Oregon Health Authority
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