

MEDICAL POLICY STATEMENT

Georgia Medicaid

Policy Name & Number	Date Effective
Gender Affirming Surgery-GA MCD-MM-0734	11/01/2023
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.



- A. Subject
Gender Affirming Surgery

- B. Background
Individuals with gender dysphoria

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

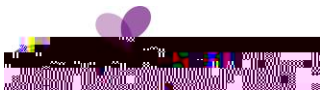


- member needs assistance with BH treatment. If a letter is provided by a psychologist, psychiatrist, or psychiatric nurse practitioner.
- a. The BH provider has evaluated the member within the past 12 months of the time of referral.
 01. If member has been in BH treatment, it is preferred that the recommendation 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 the 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 treatment, including hormonal treatment and/or surgery, as well as BH during the transition period.
 03. Member has capacity to and gave 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 with no recent, active intravenous drug use or 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 or bottom surgery (e.g., clitoroplasty, metoidioplasty, penectomy, vaginectomy, etc.) 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 healthcare provider managing care, including 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 behavior health (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 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 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 the 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. Member has a gender dysphoria diagnosis persistent for six (6) months or longer at the time of the medical necessity review request.
 02. Member has capacity to and did give informed consent for surgery.
 03. A member specific treatment plan to address treatment, including hormonal treatment and/or surgery, as well as BH during this transition period.
 04. 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.
 05. If co-existing mental illness and/or substance related disorder is present, it is relatively well controlled with no recent, active intravenous drug use or suicide attempts or behaviors.
 06. 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 reversal of surgery to revise secondary sex characteristics
 - B. abdominoplasty
 - C. blepharoplasty
 - D. brow lift

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



G. Review/Revision History

ACTION	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	Removed endocrinologist rule, added psychiatric NP, added safety considerations.
	05/19/2022	Annual review. Updated and added definitions. Criteria updated to MCG, 26th edition standards.
	06/21/2023	Annual review. Updated background and definitions, reference list. Approved at Committee.
Date Effective	11/01/2023	
Date Archived		

H. References

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2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition, text revised (DSM-5-TR). Arlington, VA, 2022
3. American Psychological Association. (2015, December), Guidelines for psychological practice with transgender and gender nonconforming people. *Amer Psych*. 70(9), 832-864. doi.org/10.1037/a0039906
4. Centers for Medicare & Medicaid (CMS). Decision memo for gender dysphoria and gender reassignment surgery (CAG 00446N). (2016, August 30). Accessed June 2, 2023. www.cms.gov
5. Ferrando C, Zhao L, & Nikolavsky D. (2021, March). Transgender surgery: female to male. Accessed June 2, 2023. www.uptodate.com
6. Hembree W, Cohen-Kettenis P, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline.

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13. World Professional Association for Transgender Health (WPATH). (8th Edition 2022). Standards of care for the health of transsexual, transgender and gender nonconforming people. Accessed June 2, 2023. www.wpath.org
14. Zhang W, Garrett G, Arron S, et al. Laser hair removal for genital gender affirming surgery. *Trans And and Uro*, 5(3), 381-387. doi:10.21037/tau.2016.03.27

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Approved DCH 08/15/2023

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