PROVIDER POLICIES & PROCEDURES

GENDER AFFIRMATION SURGERY

The primary purpose of this policy is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for gender affirmation surgery. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Gender affirmation may involve social, medical and/or legal steps that affirm a person's gender. Gender affirmation surgery is one of the possible steps in this process. This surgery includes a variety of procedures that some transgender or gender diverse people may use to affirm their gender. Gender affirming surgery includes pelvic or gonadal surgery (hysterectomy, orchiectomy, ovariectomy, or salpingo-oophorectomy), genital surgery (clitoroplasty, labiaplasty, metoidioplasty, penectomy, phalloplasty, scrotoplasty, urethroplasty, vaginectomy, vaginoplasty, or placement of penile or testicular prostheses), chest surgery (mastectomy, augmentation), facial surgery, reduction thyrochondroplasty, and voice surgery. This policy describes the procedures that are covered as part of gender affirmation surgery and the criteria that are required for coverage.

CLINICAL GUIDELINE

Coverage guidelines for gender affirmation surgery are made in accordance with the CT Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Adults

Gender affirming pelvic/gonadal, genital, and chest surgery (mastectomy/augmentation) is considered medically necessary when all of the following criteria are met:

A. The individual verbalizes understanding of the effect of gender-affirming pelvic/gonadal and genital surgical intervention on future reproduction or the effect of chest surgery on future lactation;
B. Gender incongruence/diversity is marked and sustained;
C. One referral letter from a treating provider*;
D. If significant medical or mental health concerns are present, documentation from the treating provider that they do not interfere with self-identification and do not put the individual at unreasonable risk; and
E. Stable on hormonal therapy unless medically contraindicated or not desired.

*Treating provider is a health care professional with competency in assessment of transgender and gender diverse people who have a therapeutic relationship with the individual. Examples include, but are not limited to, a qualified mental health professional, primary care provider, endocrinologist.

Other gender affirming surgery* (non-breast/chest surgeries, non-pelvic/gonadal surgeries may be considered reconstructive, and therefore medically necessary, when all of the following criteria are met:

A. Gender incongruence/diversity is marked and sustained;
B. One referral letter from a treating provider**;
C. If significant medical or mental health concerns are present, documentation from the treating provider that they do not interfere with self-identification and do not put the individual at unreasonable risk;
D. Stable on hormonal therapy unless medically contraindicated or not desired; and
E. There is no documentation or indication that the surgery or procedure is being done for any reason other than feminization, masculinization, or non-binary transition (e.g., to improve appearance unrelated to gender transition/affirmation, or to reverse the appearance of normal aging, or to correct medical or surgical problems unrelated to gender transition/affirmation [however if potentially indicated for other reasons, the surgery or procedure might be considered medically necessary reconstructive surgery].)

*Other Gender Affirming Surgery:

- Body contouring
- Facial feminization
- Facial masculinization
- Blepharoplasty
- Breast augmentation after initial augmentation mammaplasty
- Brow lift
- Calf implants
- Gluteal augmentation
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Rhinoplasty
- Thyroid cartilage reduction (chondroplasty)
- Voice modification surgery

**Treating provider is a health care professional with competency in the assessment of transgender and gender diverse people who has a therapeutic relationship with the individual. Examples include, but are not limited to, a qualified mental health professional, primary care provider, endocrinologist.

Adolescents

Gender affirming surgery for individuals under 18 years of age will be reviewed on a case-by-case basis, when all of the following criteria are met:

A. Documentation from the treating provider that includes all of the following:
    1. Gender incongruence is marked and sustained over time;
    2. A statement that the individual demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the procedure(s);
    3. A statement that the individual has been informed of the reproductive effects of the requested surgical procedure(s) in the context of their stage of pubertal development;

4. An assessment of parental/guardian support;
5. An assessment of the individual's ability to adhere to post-surgical recommendations;

B. One referral letter from a qualified mental health professional*;
C. If significant medical or mental health concerns are present, a statement from the treating provider that they are reasonably well controlled; and
D. Unless contraindicated or not desired, has received at least 12 months of gender-affirming hormone therapy, if required, to achieve the desired surgical result.

Phalloplasty is not covered in individuals under the age of 18 at this time given its complexity and high rates of complications when compared to other gender-affirming treatments.

***Characteristics of a Qualified Mental Health Professional (From WPATH SOC VIII – Mental Health):**

- Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent;
- Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes;
- Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender incongruence/diversity; and
- Knowledgeable about transgender and gender diverse individuals, and the assessment and treatment of gender incongruence/diversity.

Hair Removal/Hairplasty

- Hair removal procedures to treat tissue donor sites for a planned phalloplasty or vaginoplasty are considered medically necessary.
- The use of laser hair removal for facial feminization may be considered medically necessary if the above criteria for *other gender affirming surgery* are met.
- Electrolysis is typically considered not medically necessary. Requests will be reviewed on a case-by-case basis and may be covered for those individuals seeking hair removal as part of facial feminization when there is documentation from a treating medical provider indicating why laser hair removal is contraindicated or ineffective for the individual.
- Hair removal on other body areas (e.g., legs, arms) is considered cosmetic and not medically necessary.
- Hairplasty/hair transplants are considered cosmetic and not medically necessary.

Surgical Revision

Surgery to refine the results of a previous surgical procedure, including breast augmentation, mastectomy, facial feminization, and genital reconstruction may be considered medically necessary if the surgery is needed to address a functional impairment resulting from the previous surgery. If not reconstructive in nature, the procedure will be considered cosmetic and therefore not medically necessary.

Documentation from the medical/surgical provider describing the impairment is required.

Reversal

Reversal of a prior gender affirming surgical procedure is considered gender-affirming care. The applicable criteria, as outlined above, for gender-affirming surgical procedures would apply.

Cosmetic Procedures for Aging Skin
Procedures to address aging skin (e.g., loose skin on cheeks and jawline, wrinkles [brow furrows, frown lines, crow's feet, laugh lines etc.], eye bags, sun damage, age spots, drooping eyelids, thinning/creases/wrinkles of skin of face/chest) are not reconstructive in nature and are therefore considered *cosmetic* and *not* medically necessary. These procedures include but are not limited to:

- Chemical peels
- Dermabrasion
- Laser resurfacing
- Use of radio waves
- Intense pulsed light technology
- Botulinum toxin
- Cosmetic fillers (including collagen, hyaluronic acid injections, fat transplantation and implants)
- Facelift or other skin tightening procedures
- Brow lift
- Eyelid procedures

EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of gender affirmation surgery is required. Requests for coverage will be reviewed in accordance with the processes in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for gender affirmation surgery:

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal; and
2. Documentation from the referring provider which supports the medical necessity of the requested procedure(s), and which includes all documentation and referrals outlined in the above criteria.

EFFECTIVE DATE
This Policy is effective for prior authorization requests for gender affirmation surgery for individuals covered under the HUSKY Health Program beginning April 2, 2015.

LIMITATIONS
N/A

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- World Professional Association for Transgender Health (WPATH). Standards of care for the health of transgender and gender diverse people. 8th version. 2022. Available at: https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644 Accessed on October 23, 2022.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	April 2, 2015	Approved by DSS on April 2, 2015.
Reviewed	June 2015	Clinical Quality Subcommittee Review. Clarified language in

		Clinical Guideline section concerning need for hormone therapy. Updated reference for AMA CPT Manual to most current version.
Updated	March 2016	Updates to language in introductory paragraph pertaining to purpose of policy. Updates to Clinical Guideline section pertaining to definition of Medical Necessity. Updates throughout policy to reflect importance of person-centeredness when reviewing requests for these procedures. Added the following criteria: • Mastectomy/creation of male chest as part of male to female reassignment • Breast augmentation as part of male to female reassignment • Genital hair removal as part of male to female Reassignment • Use of hormone therapy in adolescents Updated section related to additional procedures related to gende reassignment. Removed code list. Changes approved by Clinica Quality Subcommittee on March 21, 2016. Changes approved by DSS on April 22, 2016.
Updated	Nov 2016	Update to further define the necessary qualifications of mental health professionals submitting referrals for gender reassignment surgery. Change approved at the November 9, 2016 CHNCT Medical Policy Committee meeting. Change approved at the December 20, 2017 CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on January 3, 2017.
Updated	April 2017	Added criteria for facial feminization procedures. Removed list of procedures that require case-by-case review. Changes approved by DSS on March 31, 2017. Changes approved by CHNCT Medical Policy Review Committee on April 26, 2017. Changes approved by Clinical Quality Subcommittee on June 19, 2017.
Updated	April 2018	Medical Policy Committee review. Reference update. Approved by CHNCT Medical Policy Review Committee on February 14, 2018. Approved by CHNCT Clinical Quality Subcommittee on March 19, 2018. Approved by DSS on April 5, 2018.
Updated	July 2018	Update to change gender reassignment surgery to gender affirmation surgery. Change approved by DSS on July 17, 2018.
Updated	November 2018	Update to Clinical Guideline section that referrals should be based on person-centered assessment of individual. Update to Clinical Guideline section under Facial Feminization to include statement that letter from qualified mental health professional

		"should be specific to the individual's unique experiences." Formatting changes – moved language reqarding letter/referral requirements/qualifications of mental health professional. Change approved at the November 14, 2018 CHNCT Medical Policy Review Committee meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 17, 2018. Approved by DSS on January 28, 2019.
Updated	February 2019	Added Surgical Revision to Clinical Guideline section: ***Surgical Revision*** *Surgery to refine the results of a previous surgical procedure, including breast augmentation, mastectomy, facial feminization and genital reconstruction may be considered medically necessary if the surgery is needed to address a functional impairment resulting from the previous surgery.* *Documentation from the medical/surgical provider describing the impairment is required.* Change approved at the February 27, 2019 Medical Reviewer Meeting. • Added need for hormone therapy prior to facial feminization procedures to the Clinical Guideline section. • Added section on procedures to address aging skin to the Clinical Guideline section. Changes approved at the March 13, 2019 Medical Reviewer Meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 18, 2019. Approved by DSS on March 27, 2019.
Updated	August 2020	Updated reference for AMA CPT Manual to current year's version. Change approved at the August 12, 2020 Medical Reviewer Meeting. Change approved by the CHNCT Clinical Quality Subcommittee on September 21, 2020. Approved by DSS on October 7, 2020.
Reviewed	September 2021	Reviewed and approved without changes at the September 8, 20 CHNCT Medical Reviewer meeting. Reviewed and approved without changes by the CHNCT Clinical Quality Subcommittee on September 20, 2021. Approved by DSS on September 30, 2021.
Updated	March 2022	Updates to Clinical Guideline section: • Surgery limited to individuals 18 years of age and older • Need for medical and psychological evaluations to determine capacity to make decision to proceed with surgery and to attest that any mental health or

		substance use conditions are stable and being treated • Need for two evaluations from mental health professionals, the most recent within 6 months of request • Added statement to facial feminization criteria "E. Documentation on how the individual's current facial features vary from the experienced gender, how the variation impacts the individual's current level of function, and how the procedure(s) will directly address the variatio (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive)" • Added criteria for reversal for individuals seeking to detransition/retransition • Added criteria for cosmetic procedures • Removed criteria for hormone therapy Changes approved at the March 9, 2022 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 2 2022.
Updated	May 2022	Correction to Limitations section. Removed statement that gender affirming services are not covered for HUSKY B members. Update approved by DSS on May 26, 2022.
Updated	August 2022	Updates to Clinical Guideline section. Letter requirement changed from two letters to one letter (from behavioral health clinicians) for chest surgeries and facial feminization procedures. Updated qualifications for behavioral health clinicians to mirror requirements outlined in the most current, published WPATH Standards of Care. Word "irreversible" removed throughout policy. Added APRNs to providers able to prescribe hormonal therapy. Updates to Additional Resources and References sectio Changes approved by the CHNCT Clinical Quality Subcommittee on August 2, 2022. Changes approved by DSS on August 2, 2022.
Updated	January 2023	Update to Clinical Guideline section to align with WPATH SOC Version 8. Changes approved at the December 14, 2022 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on December 19, 2022. Approved by DSS on December 22, 2022.
Updated	September 2023	Updates to introductory paragraphs to better describe the experience of transgender and gender nonconforming individuals. Update to Clinical Guideline section to clarify requirements regarding pre-surgical education about future reproduction and lactation. Updated coverage of revisional surgeries – revisional surgeries for individuals looking to reverse a previous procedure will be considered gender affirming care and criteria for gender affirming surgeries would

		apply to these procedures. Changes approved at the August 9, 2023 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on September 18, 2023. Approved by DSS on October 2, 2023.
Updated	September 2024	Clinical Guideline section updated to define treating provider. Criteria for other gender affirming surgeries updated to clarify documentation requirements. List of other gender affirming surgeries updated. Criteria for hair removal/hairplasty added. Section addressing gender affirming surgical procedures considered not medically necessary or cosmetic removed. Changes approved at the September 11, 2024 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on September 16, 2024. Approved by DSS on September 27, 2024.