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 surgery is one option in the treatment of severe cases of gender dysphoria, a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with an intense sense of discomfort with their own gender. Gender affirmation surgery is not a single procedure, but part of a complex process involving multiple medical, psychiatric and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes. Before undergoing gender affirmation surgery, important medical and psychological evaluations, medical therapies, and treatment and stabilization of comorbid mental health and substance use disorders should be undertaken and completed to confirm that surgery is the most appropriate treatment choice for the individual.

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:

Medically Necessary

Gender affirming pelvic or gonadal surgery (which may consist of a combination of the following: hysterectomy, orchiectomy, ovariectomy, or salpingo-oophorectomy), is considered medically necessary when all of the following criteria are met:

A. The individual is 18 years of age or older; and
B. The individual has been diagnosed with gender dysphoria according to the criteria outlined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by a psychiatrist, psychologist, or a master's level mental health professional licensed to practice in the state of Connecticut. The diagnosis was based on a comprehensive mental health evaluation and includes a detailed mental status examination according to current best practices. The report issued by the mental health professional diagnosing gender dysphoria must also provide: 1) a descriptive and detailed account as to presence of comorbid mental health conditions, e.g., psychotic disorders, mood disorders, post-traumatic stress disorder, and substance use disorders, and how those may be contributing to or interacting with symptoms of gender dysphoria; 2) current treatment and degree of stability of those conditions; 3) how those conditions may interfere with the outcomes of gender

affirming surgery; and 4) a detailed evaluation of the individual's capacity for making an informed medical decision regarding an invasive, body-transforming irreversible surgical treatment. The report of diagnostic evaluation must demonstrate that individual candidates for gender affirming surgery exhibit all of the following:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
2. The transsexual identity has been present persistently for at least two years; and
3. The disorder is not a symptom of another mental disorder; and
4. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

C. If the individual has significant, outstanding medical or mental health conditions present:
   1. They must be reasonably well controlled; and
   2. If the individual is diagnosed with significant medical conditions, the conditions must be well controlled. A signed letter from the treating medical practitioner attesting that the individual has been cleared for surgery is required; and
   3. If the individual is diagnosed with psychiatric disorders (e.g., schizophrenia, psychotic disorder, bipolar disorder, dissociative identity disorder, delusional disorder, borderline personality disorder, PTSD, suicidality, body dysmorphic disorder), these conditions must be well controlled before surgery is contemplated. A signed letter from the treating provider (psychiatrist or psychiatric APRN) attesting that the individual has the capacity to make fully informed decisions for medical and surgical procedures involved in the process of gender transition, that the individual's symptoms are well-controlled and that the individual is compliant with the prescribed medication regimen and/or psychotherapy plan of care must accompany the request for surgery; and
D. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and
E. Documentation* that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in the new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings); and
F. Two evaluations from qualified mental health professionals** who have independently assessed the individual. If the first evaluation is from the mental health professional diagnosing, treating or referring the individual candidate for gender affirming surgery, the second evaluation should be from a mental health professional who has evaluated the individual candidate with the specific purpose of confirming the diagnosis of gender dysphoria, and determining the individual's readiness for gender affirming surgery, including a formal assessment of the individual's capacity to make informed decisions for irreversible surgery. Two separate evaluations and reports are required and must have been signed within 12 months of the request submission with the most recent evaluation within the previous 6 months.

<u>Gender affirming genital surgery (which may consist of a combination of the following: clitoroplasty, labiaplasty, metoidioplasty, penectomy, phalloplasty, scrotoplasty, urethroplasty, vaginectomy, vaginoplasty, or placement of penile or testicular prostheses), is considered medically necessary when all of the following criteria are met:</u>

A. The individual is 18 years of age or older; and
B. The individual has been diagnosed with gender dysphoria according to the criteria outlined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by a psychiatrist, psychologist, or a master's level mental health professional licensed to practice in the state of Connecticut. The diagnosis was based on a comprehensive mental health evaluation and includes a detailed mental status examination according to current best practices. The report issued by the mental health professional diagnosing gender dysphoria must also provide: 1) a descriptive and detailed account as to presence of comorbid mental health conditions, e.g., psychotic disorders, mood disorders, post-traumatic stress disorder, and substance use disorders, and how those may be contributing to or interacting with symptoms of gender dysphoria; 2) current treatment and degree of stability of those conditions; 3) how those conditions may interfere with the outcomes of gender affirming surgery; and 4) a detailed evaluation of the individual's capacity for making an informed medical decision regarding an invasive, body-transforming irreversible surgical treatment. The report of diagnostic evaluation must demonstrate that the individual candidate for gender affirming surgery exhibit all of the following:
    1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
    2. The transsexual identity has been present persistently for at least two years; and
    3. The disorder is not a symptom of another mental disorder; and
    4. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
C. If the individual has significant, outstanding medical or mental health conditions present:
    1. They must be reasonably well-controlled; and
    2. If the individual is diagnosed with significant medical conditions, the conditions must be well controlled. A signed letter from the treating medical practitioner attesting that the individual has been cleared for surgery is required; and
    3. If the individual is diagnosed with psychiatric disorders (e.g., schizophrenia, psychotic disorder, bipolar disorder, dissociative identity disorder, delusional disorder, borderline personality disorder, PTSD, suicidality, body dysmorphic disorder), these conditions must be well controlled before surgery is contemplated. A signed letter from the treating provider (psychiatrist or psychiatric APRN) attesting that the individual has the capacity to make fully informed decisions for medical and surgical procedures involved in the process of gender transition, that the individual's symptoms are well-controlled and that the individual is compliant with the prescribed medication regimen and/or psychotherapy plan of care must accompany the request for surgery; and
D. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and
E. Documentation* that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in the new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings); and
F. Two evaluations from qualified mental health professionals** who have independently assessed the individual. If the first evaluation is from the mental health professional diagnosing, treating or referring the individual candidate for gender affirming surgery, the second evaluation should be from a mental

health professional who has evaluated the individual candidate with the specific purpose of confirming the diagnosis of gender dysphoria, and determining the individual's readiness for gender affirming surgery, including a formal assessment of the individual's capacity to make informed decisions for irreversible surgery. Two separate evaluations and reports are required and must have been signed within 12 months of the request submission with the most recent evaluation within the previous 6 months.

***** The medical documentation should include the start date of living full time in the new gender. Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases.

**At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions.

The use of hair removal procedures to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure is considered medically necessary.

Reconstructive

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

A. The individual is 18 years of age or older; and
B. The individual has been diagnosed with gender dysphoria according to the criteria outlined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by a psychiatrist, psychologist, or a master's level mental health professional licensed to practice in the state of Connecticut. The diagnosis was based on a comprehensive mental health evaluation and includes a detailed mental status examination according to current best practices. The report issued by the mental health professional diagnosing gender dysphoria must also provide: 1) a descriptive and detailed account as to presence of comorbid mental health conditions, e.g., psychotic disorders, mood disorders, post-traumatic stress disorder, and substance use disorders, and how those may be contributing to or interacting with symptoms of gender dysphoria; 2) current treatment and degree of stability of those conditions; 3) how those conditions may interfere with the outcomes of gender affirming surgery; and 4) a detailed evaluation of the individual's capacity for making an informed medical decision regarding an invasive, body-transforming irreversible surgical treatment. The report of diagnostic evaluation must demonstrate that the individual candidate for gender affirming surgery exhibits all of the following:
    1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
    2. The transsexual identity has been present persistently for at least two years; and
    3. The disorder is not a symptom of another mental disorder; and
    4. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
C. If the individual has significant, outstanding medical or mental health conditions present:
    1. They must be reasonably well-controlled; and
    2. If the individual is diagnosed with significant medical conditions, the conditions must be well-controlled. A signed letter from the treating medical practitioner attesting that the individual has been cleared for surgery is required; and

3. If the individual is diagnosed with psychiatric disorders (e.g., schizophrenia, psychotic disorder, bipolar disorder, dissociative identity disorder, delusional disorder, borderline personality disorder, PTSD, suicidality, body dysmorphic disorder), these conditions must be well controlled before surgery is contemplated. A signed letter from the treating provider (psychiatrist or psychiatric APRN) attesting that the individual has the capacity to make fully informed decisions for medical and surgical procedures involved in the process of gender transition, that the individual's symptoms are well-controlled and that the individual is compliant with the prescribed medication regimen and/or psychotherapy plan of care must accompany the request for surgery; and

D. For gender affirming breast augmentation procedures only: for individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician, and insufficient breast development has occurred; and
E. Existing chest appearance demonstrates significant variation from normal appearance for the experienced gender; and
F. Documentation* that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in the new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings); and
G. Two evaluations from qualified mental health professionals** who have independently assessed the individual. If the first evaluation is from the mental health professional diagnosing, treating or referring the individual candidate for gender affirming surgery, the second evaluation should be from a mental health professional who has evaluated the individual candidate with the specific purpose of confirming the diagnosis of gender dysphoria, and determining the individual's readiness for gender affirming surgery, including a formal assessment of the individual's capacity to make informed decisions for irreversible surgery. Two separate evaluations and reports are required and must have been signed within 12 months of the request submission with the most recent evaluation within the previous 6 months.

<u>Gender affirming facial surgery is considered reconstructive when all of the following criteria are met:</u>

A. The individual is 18 years of age or older; and
B. The individual has been diagnosed with gender dysphoria according to the criteria outlined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by a psychiatrist, psychologist, or a master's level mental health professional licensed to practice in the state of Connecticut. The diagnosis was based on a comprehensive mental health evaluation and includes a detailed mental status examination according to current best practices. The report issued by the mental health professional diagnosing gender dysphoria must also provide: 1) a descriptive and detailed account as to presence of comorbid mental health conditions, e.g., psychotic disorders, mood disorders, post-traumatic stress disorder, and substance use disorders, and how those may be contributing to or interacting with symptoms of gender dysphoria; 2) current treatment and degree of stability of those conditions; 3) how those conditions may interfere with the outcomes of gender affirming surgery; and 4) a detailed evaluation of the individual's capacity for making an informed medical decision regarding an invasive, body-transforming irreversible surgical treatment. The report of diagnostic evaluation must demonstrate that the individual candidate for gender affirming surgery exhibits all of the following:
    1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the

wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
2. The transsexual identity has been present persistently for at least two years; and
3. The disorder is not a symptom of another mental disorder; and
4. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

C. If the individual has significant, outstanding medical or mental health conditions present:
1. They must be reasonably well controlled; and
2. If the individual is diagnosed with significant medical conditions, the conditions must be well controlled. A signed letter from the treating medical practitioner attesting that the individual has been cleared for surgery is required; and
3. If the individual is diagnosed with psychiatric disorders (e.g., schizophrenia, psychotic disorder, bipolar disorder, dissociative identity disorder, delusional disorder, borderline personality disorder, PTSD, suicidality, body dysmorphic disorder), these conditions must be well controlled before surgery is contemplated. A signed letter from the treating provider (psychiatrist or psychiatric APRN) attesting that the individual has the capacity to make fully informed decisions for medical and surgical procedures involved in the process of gender transition, that the individual's symptoms are well controlled and that the individual is compliant with the prescribed medication regimen and/or psychotherapy plan of care must accompany the request for surgery; and

D. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician, and

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 addresses the variation (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and

F. Documentation* that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in the new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings); and

G. Two evaluations from qualified mental health professionals** who have independently assessed the individual. If the first evaluation is from the mental health professional diagnosing, treating or referring the individual candidate for gender affirming surgery, the second evaluation should be from a mental health professional who has evaluated the individual candidate with the specific purpose of confirming the diagnosis of gender dysphoria, and determining the individual's readiness for gender affirming surgery, including a formal assessment of the individual's capacity to make informed decisions for irreversible surgery. Two separate evaluations and reports are required and must have been signed within 12 months of the request submission with the most recent evaluation within the previous 6 months.

* The medical documentation should include the start date of living full time in the new gender. Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases.

**At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions.

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 typically not covered but may be covered and will be reviewed on a case-by-case basis.

Not Medically Necessary
The following gender affirming surgical procedures are considered not medically necessary when one or more of the medical necessary or reconstructive criteria above have not been met:

- Clitoroplasty
- Hysterectomy
- Labiaplasty
- Metoidioplasty
- Orchiectomy
- Ovariectomy
- Penectomy
- Phalloplasty
- Salpingo-Oophorectomy
- Scrotoplasty
- Urethroplasty
- Vaginectomy
- Vaginoplasty

The following procedures, when requested alone or in combination with other procedures, are considered cosmetic and not medically necessary when applicable reconstructive criteria above have not been met, or when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender affirming surgery, including, but not limited to, the following:

- Abdominoplasty
- Bilateral mastectomy
- Blepharoplasty
- Breast augmentation
- Brow lift
- Calf implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation

- Hair removal (for example, electrolysis or laser) and hairplasty, when the criteria above have not been met
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Rhinoplasty
- Thyroid cartilage reduction (chondroplasty)
- Voice modification surgery

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:

Peer Reviewed Publications:

1. Ainsworth TA, Spiegel JH. Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. Qual Life Res. 2010; 19(7):1019-24.
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3. Becking AG, Tuinzing DB, Hage JJ, Gooren LJ. Facial corrections in male to female transsexuals: a preliminary report on 16 patients. J Oral Maxillofac Surg. 1996; 54(4):413-418.
4. Blanchard R, Steiner BW, Clemmensen LH, Dickey R. Prediction of regrets in postoperative transsexuals. Can J Psychiatry. 1989; 34(1):43-45.
5. Bradley SJ, Zucker KJ. Gender identity disorder: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry. 1997; 36(7):872-880.
6. Butler RM, Horenstein A, Gitlin M, Testa RJ, et al. Social anxiety among transgender and gender nonconforming individuals: The role of gender-affirming medical interventions. J Abnorm Psychol. 2019; 128(1):25-31.
7. Capitán L, Simon D, Kaye K, Tenorio T. Facial feminization surgery: the forehead. Surgical techniques and analysis of results. Plast Reconstr Surg. 2014; 134(4):609-619.
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13. de Blok CJM, Dijkman BAM, Wiepjes CM, et al. Sustained breast development and breast anthropometric changes in three years gender-affirming hormone treatment. J Clin Endocrinol Metab. 2020a 18:dgaa841. Epub ahead of print.
14. de Blok CJM, Klaver M, Wiepjes CM, et al. Breast development in transwomen after 1 year of cross-sex hormone therapy: results of a prospective multicenter study. J Clin Endocrinol Metab. 2018; 103(2):532-538.
15. De Cuypere G, T'Sjoen G, Beerten R, et al. Sexual and physical health after sex reassignment surgery. Arch Sex Behav. 2005; 34(6):679-690.
16. de Vries AL, McGuire JK, Steensma TD, et al. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014; 134(4):696-704.
17. Djordjevic ML, Bizic MR, Duisin D, et al. Reversal surgery in regretful male-to-female transsexuals after sex reassignment surgery. J Sex Med. 2016; 13(6):1000-1007.

18. Djordjevic ML, Stanojevic D, Bizic M, et al. Metoidioplasty as a single stage sex reassignment surgery in female transsexuals: Belgrade experience. J Sex Med. 2009; 6(5):1306-1313.
19. Eldh J, Berg A, Gustafsson M. Long-term follow up after sex reassignment surgery. Scand J Plast Reconstr Surg Hand Surg. 1997; 31**(**1):39-45.
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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 versior
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 genc reassignment. Removed code list. Changes approved by Clinic Quality Subcommittee on March 21, 2016. Changes approved b DSS on April 22, 2016.
Updated	Nov 2016	Update to further define the necessary qualifications of mental health professionals submitting referrals for gender reassignmer 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 c procedures that require case-by-case review. Changes approved by DSS on March 31, 2017. Changes approved by CHNCT Medical Policy Review Committe 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. Approve 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 th Clinical Guideline section. Changes approved at the March 13, 2019 Medical Reviewer Meeting. Changes approved by the CHNCT Clinical Quality Subcommitte 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, 2021 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 addresses the variation (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" • 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 24, 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.