

Children's Hospital and Health System Chorus Community Health Plans Policy and Procedure

This policy applies to the following entity(s):

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| <input type="checkbox"/> CHW – Milwaukee | <input type="checkbox"/> CHW - Fox Valley |
| <input type="checkbox"/> CHHS Foundation | <input type="checkbox"/> CHW - Surgicenter |
| <input type="checkbox"/> CHW – Community Services Division | <input checked="" type="checkbox"/> Chorus Community Health Plans |
| <input type="checkbox"/> Children's Medical Group - Primary Care | <input type="checkbox"/> Children's Specialty Group |
| <input type="checkbox"/> Children's Medical Group - Urgent Care | <input type="checkbox"/> CHHS Corporate Departments |

Medical Utilization Management Policy

SUBJECT: GENDER DYSPHORIA SERVICES

INCLUDED PRODUCT(S):

Medicaid

BadgerCare Plus

Care4Kids Program

Individual and Family

Commercial

Marketplace

PURPOSE OR DESCRIPTION:

The purpose of this policy is to define medically necessary criteria for services to treat members diagnosed with gender dysphoria.

DEFINITIONS:

Gender Dysphoria: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)¹ defines gender dysphoria in adolescents and adults as a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young

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adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)

- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- 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)

In order to meet criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Qualified Mental Health Provider²: The certifications of a mental health provider that qualifies them to diagnose gender dysphoria for purposes of this policy are as follows:

- 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 appropriate certification for treating trans identified members
- 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 dysphoria
- Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria
- 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

CCHP reserves the right to request a member be seen by an additional mental health provider if documentation submitted for review is authored by a provider who does not meet all of these criteria.

Referral Letter for Surgery²: Surgical treatments for gender dysphoria require at least one referral letter from a qualified mental health professional. The recommended content of a referral letter for surgery is as follows:

- The member's general identifying characteristics
- Results of the member's psychosocial assessment, including any diagnoses
- The duration of the mental health professional's relationship with the member, including the type of evaluation and therapy or counseling to date
- An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery
- A statement about the fact that informed consent has been obtained from the member

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- A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this

POLICY:

Chorus Community Health Plans (CCHP) considers services to treat gender dysphoria medically necessary when all of the following criteria are met:

HORMONE THERAPY

1. Puberty Suppressing Hormone Therapy

- a. Puberty suppressing hormone therapy for Chorus Community Health Plans - BadgerCare Plus and Chorus Community health Plans - Care4Kids members is managed through Wisconsin ForwardHealth as a pharmacy benefit. Most of these hormones require prior authorization by criteria determined by the ForwardHealth pharmacy plan. Please see ForwardHealth pharmacy portal for further details.³
- b. Puberty suppressing hormone therapy for Chorus Community Health Plans - Marketplace and Commercial members is administered as a pharmacy benefit. Most of these hormones require a prior authorization by criteria determined by the Together pharmacy program. Please see the Chorus Community Health Plans - Marketplace and Commercial Prescription Medication List for further details.⁴

2. Gender Affirming Hormone Therapy:

- a. Gender affirming hormone therapy for CCHP BadgerCare Plus and Care4Kids members is managed through Wisconsin ForwardHealth as a pharmacy benefit. Most of these hormones require a prior authorization by criteria determined by the ForwardHealth pharmacy plan. Please see ForwardHealth pharmacy portal for further details.³
- b. Gender affirming hormone therapy for Chorus Community Health Plans - Marketplace and Commercial members is administered as a pharmacy benefit. Most of these hormones require a prior authorization by criteria determined by the Together pharmacy program. Please see the Chorus Community Health Plans - Marketplace and Commercial Prescription Medication List for further details.⁴

GENDER REASSIGNMENT SURGERY:

1. Requirements for mastectomy for female-to-male patients include all:

- a. One letter of referral from a qualified mental health professional
- b. Persistent, well-documented gender dysphoria
- c. Capacity to make a fully informed decision and to consent for treatment
 - 1. If less than 18 years of age consent from the minor and the minor’s parent or legal guardian who has the authority to consent to such health care decisions is necessary
 - 2. CCHP reserves the right to request a second opinion visit with a pediatric gender dysphoria multidisciplinary team prior to approval of surgery for a minor

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- d. If significant medical or mental health concerns are present, they must be reasonably well controlled and there must be documentation it is safe to proceed with surgery

Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

2. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male or orchiectomy in male-to-female) include all:

- a. Two referral letters from qualified mental health professionals, one may be in a purely evaluative role (meaning not providing ongoing 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 or older)
- e. If significant medical or mental health concerns are present, they must be reasonably well controlled and there must be documentation it is safe to proceed with surgery
- f. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones). The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

Note that these criteria do not apply to members who are having these procedures for medical indications other than gender dysphoria.

3. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female), include all:

- a. Two referral letters from qualified mental health professionals, one may be in a purely evaluative role (meaning not providing ongoing therapy)
- b. Persistent, well-documented gender dysphoria
- c. Capacity to make a fully informed decision and to consent for treatment
- d. Age of majority (age 18 years and older)
- e. If significant medical or mental health concerns are present, they must be reasonably well controlled and there must be documentation it is safe to proceed with surgery
- f. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)
- g. Twelve continuous months of living in a gender role that is congruent with their gender identity (real life experience). This experience provides ample opportunity for patients to experience and socially adjust to their desired gender role, before undergoing irreversible surgery.

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4. CCHP considers the following procedures that may be performed as a component of gender dysphoria treatment as cosmetic, and they will not be covered. This list is a sample and not all-inclusive:

- a. Abdominoplasty
- b. Blepharoplasty
- c. Breast augmentation
- d. Brow lift
- e. Calf implants
- f. Cheek/malar implants
- g. Chin/nose implants
- h. Collagen injections
- i. Construction of a clitoral hood
- j. Drugs for hair loss or growth
- k. Face lifting or reduction
- l. Forehead lift
- m. Hair removal
- n. Hair transplantation
- o. Lip enhancement or reduction
- p. Liposuction or body contouring
- q. Mastopexy
- r. Neck tightening
- s. Pectoral implants
- t. Reduction thyroid chondroplasty
- u. Removal of redundant skin
- v. Rhinoplasty
- w. Skin resurfacing
- x. Voice modification surgery
- y. Voice therapy/voice lessons
- z. Any other procedure who's primary purpose is to enhance the member's physical appearance only.

Note on gender specific services for the transgender community:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. We endorse United States Preventive Services Task Force⁵ recommendations for screening and preventive interventions for transgender persons as appropriate to their specific anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male trans identified persons who have not undergone a mastectomy;

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2. Prostate cancer screening may be medically necessary for male to female trans identified persons who have retained their prostate.
3. Cervical cancer screening may be medically necessary for female to male trans identified persons who have retained their cervix.

References:

1. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition.* American Psychiatric Association. 2013
2. World Professional Association for Transgendered Health (WPATH) guidelines
<https://www.wpath.org/publications/soc>
3. ForwardHealth Pharmacy Portal
<https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/pharmacy/resources.htm.spage#>
4. Chorus Community Health Plans - Marketplace and Commercial Prescription Medication List
<https://choruscommunityhealthplans.org/Members/Marketplace/Pharmacy-Services>
5. United States Preventative Services Task Force
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>

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