

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

This policy applies to the following entity(s):

- | | |
|--|---|
| <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-AFFIRMING MEDICAL AND SURGICAL 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 gender affirming care.

DEFINITIONS:

Gender-affirming care: The World Health Organization (WHO)⁴ defines gender-affirming care as social, psychological, behavioral, and medical interventions designed to support and affirm an individual's gender identity when it conflicts with the gender they were assigned at birth. As noted by the American Psychiatric Association,¹ gender identity can include individuals along a continuum.

The American Medical Association⁴ and other specialty medical societies recommend gender-affirming care as medically necessary for improving the physical and mental health of transgender people, and outline this care through evidence-based clinical guidelines.

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Developed by: CCHP Medical Directors

Qualified Health Care Professional:^{1,4} The minimum requirements of a health care professional licensed by a statutory body that qualifies them to diagnose gender incongruence for purposes of this policy are as follows:

- Master's or higher degree in a clinical field relevant to the role of assessing and diagnosing transgender and gender diverse people, granted by an institution accredited by the appropriate national accrediting board:
 - Mental health professional who holds a master's degree or higher
 - Medical practitioner (for example, Doctor of Medicine [MD], Doctor of Osteopathic Medicine [DO], certified physician assistant [PAC]), nurse practitioner [NP] with authority to diagnose
 - Other qualified health care professional who holds a master's degree or higher
- Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the World Health Organization's International Classification of Disease (ICD) for diagnostic purposes
- Ability to recognize and diagnose co-existing mental health or other psychosocial concerns and to distinguish these from gender incongruence
- Ability to assess capacity to consent to treatment
- Knowledge about gender nonconforming identities and expressions, and the assessment and treatment of gender incongruence
- Continuing education in the assessment and treatment of gender incongruence. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a health care professional with relevant experience; or participating in research related to gender nonconformity and gender incongruence

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

Referral Letter for Surgery:⁶ In addition to criteria listed elsewhere, a referral letter for any gender affirming surgery must contain:

- One of the following ICD-10 diagnoses:⁴
 - F64.0 (Transsexualism)
 - F64.1 (Dual role transvestism)
 - F64.2 (Gender identity disorder of childhood)
 - F64.8 (Other gender identity disorder)
 - F64.9 (Gender identity disorder, unspecified)
 - F66 (Other sexual disorders)
 - Z41.8 (Encounter for other procedures for purposes other than remedying health state)
 - Z41.9 (Encounter for procedure for purposes other than remedying health state, unspecified)
 - Z87.890 (Personal history of sex reassignment)
- The duration of the qualified health care professional's relationship with the member, including the type of evaluations performed
- 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

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

HORMONE THERAPY:

1. Puberty Suppressing Hormone Therapy:

- a. Puberty suppressing hormone therapy for CCHP BadgerCare Plus and 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 CCHP Individual and Family Plans members is administered as a pharmacy benefit. Most of these hormones require a prior authorization by criteria determined by the Individual and Family Plans pharmacy program. Please see the CCHP Individual and Family Plans Prescription Medication List for further details.⁵

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 CCHP Individual and Family Plans members is administered as a pharmacy benefit. Most of these hormones require a prior authorization by criteria determined by the CCHP Individual and Family Plans pharmacy program. Please see the CCHP Individual and Family Plans Prescription Medication List for further details.⁵

GENDER-AFFIRMING SURGERY:

Requests for gender-affirming surgical procedures must be made by a surgeon who has maintained an active practice in gender-affirming surgical procedures.⁴

1. Requirements for mastectomy, reduction mammoplasty and/or nipple resizing for assigned female at birth (AFAB) members include all:

- a. At least one letter of referral from a qualified health care professional documenting ALL of the following:
 - i. Marked and sustained gender incongruence
 - ii. The procedure will support gender-affirming care, and the procedure is not requested for cosmetic purposes
 - iii. Capacity to make a fully informed decision and consent to treatment
 1. If less than 18 years of age:
 - a. Consent from the minor and the minor's parent or legal guardian who has the authority to consent to such health care decisions¹
 - b. CCHP reserves the right to request a second opinion visit with a pediatric gender incongruence multidisciplinary team prior to approval of surgery for a minor
 - iv. If significant medical or mental health concerns are present, they are reasonably well controlled and it is safe to proceed with surgery

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- v. The after-care plan for surgical care
- b. CCHP reserves the right to request a second letter from a qualified health care professional prior to approval of surgery, to clarify and/or validate that these criteria are adequately met.
- c. If the member is 40 years of age or older, they have had a negative (for cancer) mammogram that was performed within the year prior to the date of planned mastectomy, reduction mammoplasty and/or nipple resizing.⁴

A trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy, reduction mammoplasty and/or nipple resizing for AFAB adult members. Twelve months of gender-affirming hormone therapy, or longer, is required for AFAB adolescents, to achieve the desired surgical result for gender-affirming procedures, unless hormone therapy is either not desired or is medically contraindicated.

2. Requirements for breast augmentation and/or nipple resizing for assigned male at birth (AMAB) members include all:

- a. At least one letter of referral from a qualified health care professional documenting ALL of the following:
 - i. Marked and sustained gender incongruence
 - ii. The procedure will support gender-affirming care, and the procedure is not requested for cosmetic purposes
 - iii. Capacity to make a fully informed decision and consent to treatment
 - 1. If less than 18 years of age:
 - a. Consent from the minor and the minor's parent or legal guardian who has the authority to consent to such health care decisions¹
 - b. CCHP reserves the right to request a second opinion visit with a pediatric gender incongruence multidisciplinary team prior to approval of surgery for a minor
 - iv. If significant medical or mental health concerns are present, they are reasonably well controlled and it is safe to proceed with surgery
 - v. The after-care plan for surgical care
- b. CCHP reserves the right to request a second letter from a qualified health care professional prior to approval of surgery, to clarify and/or validate that these criteria are adequately met.

A trial of hormone therapy is not a pre-requisite to qualifying for a breast augmentation and/or nipple resizing for AMAB adult members. Twelve months of gender-affirming hormone therapy, or longer, is required for AMAB adolescents, to achieve the desired surgical result for gender-affirming procedures, unless hormone therapy is either not desired or is medically contraindicated.

3. Requirements for gonadectomy (hysterectomy and/or oophorectomy in AFAB or orchiectomy in AMAB) include all:

- a. Age of majority (18 years of age or older)
- b. At least one letter of referral from a qualified health care professional documenting ALL of the following:
 - i. Marked and sustained gender incongruence

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- ii. The procedure will support gender-affirming care, and the procedure is not requested for cosmetic purposes
- iii. Capacity to make a fully informed decision and consent to treatment
- iv. If significant medical or mental health concerns are present, they are reasonably well controlled and it is safe to proceed with surgery
- v. The provider/team has discussed the effect of any gender-affirming surgical intervention on reproduction
- vi. The after-care plan for surgical care
- c. CCHP reserves the right to request a second letter from a qualified health care professional prior to approval of surgery, to clarify and/or validate that these criteria are adequately met.
- d. Six 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 member undergoes irreversible surgical intervention.

These criteria do not apply to members who are having these procedures for medical indications other than gender incongruence.

4. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty (including placement of penile/testicular prosthesis), phalloplasty (including placement of penile/testicular prosthesis), scrotoplasty, and placement of a testicular prosthesis and/or erectile prosthesis in AFAB; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in AMAB) must include all:

- a. Age of majority (18 years of age or older)
- b. At least one letter of referral from a qualified health care professional documenting ALL of the following:
 - i. Marked and sustained gender incongruence
 - ii. The procedure will support gender-affirming care, and the procedure is not requested for cosmetic purposes
 - iii. Capacity to make a fully informed decision and consent to treatment
 - iv. If significant medical or mental health concerns are present, they are reasonably well controlled and it is safe to proceed with surgery
 - v. The provider/team has discussed the effect of any gender-affirming surgical intervention on reproduction
 - vi. The after-care plan for surgical care
- c. CCHP reserves the right to request a second letter from a qualified health care professional prior to approval of surgery, to clarify and/or validate that these criteria are adequately met.
- d. Six 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 genital reconstructive surgery is primarily to introduce a period of reversible estrogen or testosterone suppression before the member undergoes irreversible surgical intervention.

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These criteria do not apply to members who are having these procedures for medical indications other than gender incongruence.

5. **Requirements for gender-affirming facial surgery (brow lift, cheek/malar implants, thyroid chondroplasty, rhinoplasty), body contouring (calf implants, chin/nose implants, pectoral implants), voice therapy and/or surgery (anterior glottal web formation, cricothyroid approximation, laser reduction glottoplasty), hair transplantation or hair removal from the face, body, and/or genital areas for gender affirmation or as part of a preoperative preparation process must include all:**
 - a. At least one letter of referral from a qualified health care professional documenting ALL of the following:
 - i. Marked and sustained gender incongruence
 - ii. The procedure will support gender-affirming care, and the procedure is not requested for cosmetic purposes
 - iii. Capacity to make a fully informed decision and consent to treatment
 1. If less than 18 years of age:
 - a. Consent from the minor and the minor's parent or legal guardian who has the authority to consent to such health care decisions¹
 - b. CCHP reserves the right to request a second opinion visit with a pediatric gender incongruence multidisciplinary team prior to approval of surgery for a minor
 - iv. If significant medical or mental health concerns are present, they are reasonably well controlled and it is safe to proceed with surgery
 - v. The after-care plan for surgical care
 - b. CCHP reserves the right to request a second letter from a qualified health care professional prior to approval of surgery, to clarify and/or validate that these criteria are adequately met.

A trial of hormone therapy is not a pre-requisite to qualifying for the above procedures.

6. **Procedures to remedy postoperative complications of gender-affirming surgery (for example, chronic infection, pain, scarring or stenosis) are not considered a separate gender-affirming surgery.⁴**
7. **Reversal of previous gender-affirming surgery is considered a separate gender-affirming surgery. Coverage and prior authorization approval criteria for gender-affirming surgery apply.⁴**

For the above listed gender-affirming surgeries, although co-morbidities may exist, the member's gender incongruence about body parts or function is not a result of any other physical and/or mental health condition, and other possible causes of gender incongruence have been excluded.

- Any physical and/or mental health conditions that could negatively impact the outcome of gender affirming medical and surgical treatments are assessed, with risks and benefits discussed, before a treatment decision is made (for instance, a transgendered member who is unable to engage with the process of transition or would be unable to manage aftercare following surgery, even with support).⁴

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Additional medical necessity criteria for members under 18 years of age:^{1,4}

1. Documentation shows that the experience of gender incongruence is marked and sustained over time.
2. The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent to treatment.
3. The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed.
4. The adolescent has been informed of the reproductive effects, including the potential loss of fertility and available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
5. The adolescent had at least 12 months of gender-affirming hormone therapy, or longer, if required, to achieve the desired surgical result for gender-affirming procedures, unless hormone therapy is either not desired or is medically contraindicated.
6. A care team consisting of providers experienced in adolescent behavioral health and gender identity has extensively explored all psychological, family, and social issues the member may have, and these issues have been actively considered during the treatment recommendation.
7. Any recommended irreversible physical interventions must be addressed in the context of adolescent development.
8. The adolescent's shift toward gender conformity is not occurring primarily to please a parent or guardian, nor for any other social reinforcement. Procedures must be supported by documentation of long-term gender identification.
9. For irreversible surgical interventions, documentation must include that the member has actively participated in a staged process through fully reversible and partially reversible interventions, as indicated by the World Professional Association for Transgender Health (WPATH). Adequate time must have passed for the member and their parent or guardian to assimilate the member's gender identity and receive adequate support as a family.

Cancer screening recommendations:

We endorse the United States Preventive Services Task Force (USPSTF)⁷ recommendations for screening and preventive interventions for transgender members as appropriate to their specific anatomy, and consider these services medically necessary. Examples include:

1. Breast cancer screening may be medically necessary for AFAB trans identified members who have not undergone a mastectomy.
2. Prostate cancer screening may be medically necessary for AMAB trans identified members who have retained their prostate.
3. Cervical cancer screening may be medically necessary for AFAB trans identified members who have retained their cervix.

References:

1. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health* 2022, 23: 1-253
2. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition.* American Psychiatric Association. 2013

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3. ForwardHealth Pharmacy Portal
<https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/pharmacy/resources.htm.spage#>
4. ForwardHealth Topic Topic #21317
<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>
5. Prescription Medication List for Chorus Community Health Plans Individual and Family Plans
<https://chorushealthplans.org/our-plans/prescription-coverage>
6. World Professional Association for Transgendered Health (WPATH) guidelines
<https://www.wpath.org/publications/soc>
7. United States Preventative Services Task Force
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>

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