Last Approval: 4/13/2022
Next Review Due By: April 2023

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Transgender refers to an individual whose sex assigned at birth (e.g., typically based on external genitalia) does not match their gender identity (one's psychological sense of their gender). **Gender dysphoria** (previously gender identity disorder) may occur in some individuals; this includes the psychological distress resulting from an incongruence between one's sex assigned at birth and one's gender identity. Gender dysphoria frequently starts in childhood however some may not experience it until adolescence or later. To have multiple domains of gender affirmation, someone who is transgender may seek affirmation in all, or some, in the following ways (APA, 2020):

- Socially (changing their name and pronouns);
- Legally (changing gender markers on government-issued documents);
- Medically (pubertal suppression or gender-affirming hormones); and/or
- Surgically (vaginoplasty, facial feminization surgery, breast augmentation, masculine chest reconstruction, etc.)

Gender identity is unlike **gender expression.** Gender identity refers to an individual's psychological sense of their gender – gender expression refers to the way in which one presents to the world in a gendered way. For example, in the United States, wearing a dress is a feminine form of gender expression while wearing a suite is a masculine form. Culturally defined expectations vary across time and culture. An individual's gender expression does not always align with their gender identity. Gender identity is also unlike **sexual orientation** which refers to the type of individual someone is sexually attracted to.; those who are transgender have the same diversity of sexual orientations as those who are cisgender. (APA, 2020).

NOTE: For common terms used when discussing gender dysphoria and gender care, please refer to the *Supplemental Information* section below.

Levin et al. (2021) note that awareness of an individual's gender identity begins very early in life. Consciousness of physical differences occurs between the 1 and 2 years of age; by age 3, children are able to identify themselves as a boy or a girl and by age 4 a child's gender identity is stable. A child's gender identity becomes more established during middle childhood and can be reflected in their interest in playing more exclusively with those of their own gender as well as taking interest in acting like, looking like, and having things similar to same-sex peers. Some children may display gender-role confusion – for example, a boy may lack interest in traditionally masculine activities and identify with females and/or feminine traits. The same can occur for girls who may identify more with males and/or masculine traits. Due to this conflict about one's gender, the child may dislike the parts of themselves that is a boy or a girl; resolution occurs by the time a child completes adolescence however some may continue to experience dysphoria and seek treatment to transition to the opposite gender.

According to federal and state population studies from 2016, approximately 1.4 million to 1.65 million adults (0.6-0.7% of the total population) and 150,000 youths in the United States identify as transgender (UCLA, 2022; ACOG, 2021). Cedars Sinai conducted a study that included 210 adults (155 transgender women, 55 transgender men) who sought gender-affirming surgery. Results showed that gender dysphoria was first experience by age 7 in 73% of transgender women and 78% of transgender men. Before starting social transition and/or hormonal therapy, transgender women

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waited 27 years on average while transgender men waited 23 years. These findings indicate that individuals who begin counseling and support services earlier likely would have lessened the distress and negative health effects that many transgender individuals encounter as well as improved overall quality of life. (Cedars Sinai, 2020).

Etiology of Gender Dysphoria

Research is ongoing however gender dysphoria may originate from a complex biopsychosocial link. Growing research also shows a correlation between gender dysphoria and childhood abuse, neglect, maltreatment, and physical or sexual abuse. Those with gender dysphoria and higher rates of body dissatisfaction typically have a poor prognosis with respect to mental health. These individuals also report higher rates of depression, suicidal ideations, and substance use. (Garg et al., 2021).

History and Physical

Patients typically present to a primary care physician, endocrinologist, or mental health provider. It is essential that the healthcare team document a good history of the patient and should include a developmental history including their childhood, education status, academic performance, social support, history of trauma (mental, physical, sexual), legal history, and if they are currently married, have a partner, or have children. A patient's psychiatric history should include any previous suicide attempts, self-injury behavior, and previous inpatient psychiatric condition(s), including if the patient has a psychiatrist or a psychotherapist and any past psychiatric treatment / medication use. Substance use should also be noted (Garg et al., 2021).

Treatment and Management

Due to more social acceptance and improved access to care, this population is presenting earlier before puberty whereas in the past individual's may have presented at adulthood or late adolescence. Providers should make necessary referrals according to the unique needs of the patient in an effort to build support. For children, individual, family, and group therapy is recommended to explore and counsel on issues stemming from gender preference. For adolescents, the anticipation of puberty is a concern; hormonal treatment and psychotherapy should be considered simultaneously. For adults, options include psychotherapy as well as hormonal and surgical treatments. Counseling is recommended to begin prior to starting treatment and should include, at minimum: (Garg et al., 2021)

- **Care Team.** A comprehensive approach with an endocrinologist and mental health providers.
- **Expectations.** While transgender hormonal and surgical treatment options will be helpful in addressing the patient's external appearance to align with their gender identity, providers should discuss unrealistic expectations sufficiently. A supportive system of peers, friends, and family is also helpful.
- **Treatment Risks.** Providers should discuss potential risks including venous thromboembolism, bone mineral density changes, and pubertal suppression.
- **Fertility Preservation.** Prior to initiation of hormonal and surgical treatment, the patient may lose the ability to reproduce. Providers should discuss fertility preservation with the patient.
- **Sexual Health.** Higher rates of sexually transmitted infections, including HIV, which are higher in this population.

Additional information can be found below in the *Summary of Medical Evidence* section, including a summary of the World Professional Association for Transgender Health (WPATH) *Standards of Care*.

Surgical Procedures for Transgender Individuals
(ACOG, 2021; WPATH, 2012)

Masculinizing surgical procedures may include the following:

- **Breast or Chest Surgery.** Subcutaneous mastectomy, creation of a male chest.
- **Genital Surgery.** Hysterectomy (with or without salpingo-oophorectomy), reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection or testicular prostheses.

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- **Nongenital, Nonbreast Surgical Interventions.** Voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Feminizing surgical procedures may include the following:

- **Breast or Chest Surgery.** Augmentation mammoplasty (implants/lipofilling).
- **Genital Surgery.** Penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty.
- **Non-Genital, Non-Breast Surgical Interventions.** Facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

Health Disparities for Transgender Youth

Levine et al. (2013) note a lack of research on transgender youth in the areas of medical, mental health, and substance abuse issues. The population also experiences family and/or peer rejection, harassment, trauma, abuse, legal problems, educational problems, poverty and homelessness. Transgender people face extremely high rates of verbal harassment and physical violence both at home and school. Mental health issues faced by transgender youth including depression and suicidality, anxiety, body image distortion, substance abuse, and post-traumatic stress disorder.

Healthy People 2020 has included a topic on *Lesbian, Gay, Bisexual, and Transgender Health* to improve the health, safety, and well-being of this population. A summary of items related to transgender health is below:

- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or lesbian, gay, or bisexual individuals.
- Prevention efforts of violence and homicide toward the transgender population is needed.
- Recognition of transgender health needs is medically necessary.

COVERAGE POLICY

Medicaid

Please note that there may be State Medicaid mandates and Health Plan regulations regarding coverage of gender dysphoria treatment. Refer to the State's current information prior to applying this policy; State mandates and/or regulations supersede this policy.

This policy addresses the surgical treatment of gender dysphoria. For specific hormone therapy criteria, please see *Pharmacy PA Criteria: Gender Dysphoria Hormone Therapy (Policy Number C17908-A)*. The following Molina Clinical Policies are also available: *Breast Implant Removal (MCP-315)* and *Blepharoplasty (MCP-204).*

Please see the *Appendix* section at the end of this policy for additional State coverage information.

Initial Criteria

1. Surgical treatment **may be considered medically necessary** when **ALL** of the following criteria are met:
   a. Member is age 18 years or older; **AND**
   b. A gender reassignment treatment plan is created specific to the Member; **AND**
   c. Member has the capacity to make a fully informed decision and to consent for treatment; **AND**
   d. Member has a documented diagnosis of gender dysphoria as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V)* including a marked incongruence between one's experienced/expressed gender and assigned gender of at least six months' duration as manifested by at least **TWO** of the following:
      i. 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); **OR**

ii. 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 adolescents, a desire to prevent the development of the anticipated secondary sex characteristics); **OR**
iii. A strong desire for the primary and/or secondary sex characteristics of the other gender; **OR**
iv. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender); **OR**
v. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender); **OR**
vi. 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).

AND

e. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning as evidenced by documentation from a behavioral health professional as defined by the World Professional Association for Transgender Health (WPATH)**. Documentation should indicate that the Member meets **ALL** of the following clinical criteria:
   i. Diagnosis of gender dysphoria; **AND**
   ii. Co-morbid psychiatric or other medical conditions are stable, and the Member is clinically cleared to undergo surgery; **AND**
   iii. Completion of twelve (12) months of continuous, full-time, real-life experience (e.g., the act of fully adopting a new or evolving gender role or gender presentation in everyday life) in the desired gender; **AND**
   iv. While the duration of needed treatment and number of sessions is up to the discretion of the behavioral health professional, documentation in the medical record should reflect the Member's understanding of all applicable medical, pharmaceutical, and behavioral health therapies (including risks and complications).

AND

f. When medically indicated, there is documentation that the Member has participated in twelve (12) consecutive months of cross-sex hormone therapy of the desired gender continuously and responsibly (e.g., screenings and follow-ups with the professional provider). Any Member contraindications should be documented.

NOTE: The purpose of mental health evaluations and referral letters for surgery is to ensure that the Provider(s) responsible for the care of the Member understand the Member's medical history.

** To avoid delays in medical necessity determinations, Providers may request sample referral letters from the surgeon and/or hospital. The following suggestions align with WPATH guidance: (WPATH, 2013).

1. Letter must be written at least twelve (12) months prior to the date of the Member's surgery consult. To ensure best surgery outcomes, the timeframe may be shortened dependent upon the nature of the Member's treatment plan; **AND**
2. For Members undergoing mastectomy (male chest contouring), breast augmentation, hysterectomy, laryngeal shave, and most facial surgeries, <u>one</u> letter is needed to document satisfaction of any applicable criteria. For Members undergoing metoidioplasty, phalloplasty, and vaginoplasty, <u>two</u> letters are required; **AND**
3. Letters should include the following:
   a. Member identifying information (e.g., general identification [age, sex/gender, relationship status, race/ethnicity] and reason surgery is being sought); **AND**
   b. Duration and nature of the therapeutic relationship with the Member, including evaluation, treatment type, and duration; **AND**
   c. Explanation of how the Member meets criteria <u>and</u> a brief clinical reason to support the Member's surgery. This includes the Member's capacity to make an informed decision and consent about treatment. For Member's undergoing genital surgery, twelve (12) months of continuous cross gender hormone therapy should be documented unless there are contraindications and/or the Member is unable/unwilling to use hormones; **AND**
   d. Summary of the Member's psychosocial assessment that includes, but is not limited to: diagnoses; chronological history of the Member's cross-gender feelings; initial and current gender and any sexual, psychiatric (personality, developmental), and/or substance abuse diagnoses; **AND**
   e. Background related to family, development, education and occupation, relational and social history; **AND**
   f. Documentation of Member's current psychiatric stability and if the diagnosis is controlled; **AND**
   g. Medication listing (medical and psychiatric) including dosage, starting date, and prescribing Provider; **AND**
   h. Expected support level from the Member's family, friends, colleagues, etc.; **AND**
   i. Legal status of gender change (including name and gender) on identification (e.g., birth certificate, driver's license passport); **AND**

j. Qualifications of the evaluator and/or letter author including appropriate level of education, supervision, training and State credentials to treat individuals with gender dysphoria and who seek treatment (including continuing education opportunities); experience utilizing the DSM-V; the ability to recognize and diagnose co-morbid behavioral health concerns and differentiate from gender dysphoria; and a strong understanding of gender non-conforming identities and expressions (including how to assess and treat individuals with gender dysphoria).

2. Surgical procedures **may be considered medically necessary** when applicable criteria are met for **ANY/ALL** of the following:

   a. For Male-to-Female (MtF) procedures:

   - Breast Augmentation Mastoplasty when indicated by **ALL** of the following:
     i. Referral letter from a qualified behavioral health Provider confirming **ALL** of the following:
        - Member has a documented diagnosis of persistent gender dysphoria; **AND**
        - Member has an understanding of potential risks, harms, and irreversibility of procedure; **AND**
        - Member has full decision-making capacity to give fully informed consent; **AND**
        - There is documented appropriateness for the proposed surgery (e.g., clinical rationale supporting the request for surgery); **AND**
        - Appropriate psychosocial assessment confirms that comorbid mental health issues are absent or under control. This includes, but is not limited to, substance abuse, major depression, and bipolar disorder.

     ii. Member has undergone at least 12 months of continuous hormone therapy consistent with gender dysphoria treatment goals (e.g., estrogen) or reason for contraindication, as documented by a Provider (e.g., endocrinologist, primary care).

   OR

   - Orchiectomy when indicated by **ALL** of the following:
     i. Two referral letters from mental health professionals who have independently assessed patient, one of whom is acting in a purely evaluative capacity (not involved in long-term care), with each letter attesting to **ALL** of the following:
        - Member has a documented diagnosis of persistent gender dysphoria; **AND**
        - Member has an understanding of potential risks, harms, and irreversibility of procedure; **AND**
        - Member has full decision-making capacity to give fully informed consent; **AND**
        - There is documented appropriateness for the proposed surgery (e.g., clinical rationale supporting the request for surgery); **AND**
        - Appropriate psychosocial assessment confirms that comorbid mental health issues are absent or under control. This includes, but is not limited to, substance abuse, major depression, and bipolar disorder.

     ii. Member has undergone at least 12 months of continuous hormone therapy consistent with gender dysphoria treatment goals (e.g., estrogen) or reason for contraindication, as documented by a Provider (e.g., endocrinologist, primary care).

   OR

   - Genital Reconstructive Surgery (e.g., vaginoplasty, penectomy, labioplasty, clitoroplasty)
     i. Two referral letters from mental health professionals who have independently assessed patient, one of whom is acting in a purely evaluative capacity (not involved in long-term care), with each letter attesting to **ALL** of the following:
        - Member has a documented diagnosis of persistent gender dysphoria; **AND**
        - Member has an understanding of potential risks, harms, and irreversibility of procedure; **AND**
        - Member has full decision-making capacity to give fully informed consent; **AND**
        - There is documented appropriateness for the proposed surgery (e.g., clinical rationale supporting the request for surgery); **AND**
        - Appropriate psychosocial assessment confirms that comorbid mental health issues are absent or under control. This includes, but is not limited to, substance abuse, major depression, and bipolar disorder.

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ii. Member has undergone at least 12 months of continuous hormone therapy consistent with gender dysphoria treatment goals (e.g., estrogen) or reason for contraindication, as documented by a Provider (e.g., endocrinologist, primary care).
iii. Documentation that the Member has lived in the gender role consistent with their gender identity for at least 12 months.

OR

- Voice Disorders when the Member meets **ALL** of the following:
  i. Diagnosis of voice disorder; **AND**
  ii. Evidence of voice-gender incongruence (if the Member is undergoing voice rehabilitation).

Additional procedures that **may be considered medically necessary** include:

- Electrolysis (when required for vaginoplasty)**; OR**
- Mammaplasty**; OR**
- Prostatectomy**; OR**
- Urethroplasty**; OR**
- Vulvoplasty.

OR

b. For Female-to-Male (FtM) procedures:

- Mastectomy when medically necessary as indicated by referral letter from a qualified behavioral health Provider confirming **ALL** of the following:
  i. Member has a documented diagnosis of persistent gender dysphoria; **AND**
  ii. Member has an understanding of potential risks, harms, and irreversibility of procedure; **AND**
  iii. Member has full decision-making capacity to give fully informed consent; **AND**
  iv. There is documented appropriateness for the proposed surgery (e.g., clinical rationale supporting the request for surgery); **AND**
  v. Appropriate psychosocial assessment confirms that comorbid mental health issues are absent or under control. This includes, but is not limited to, substance abuse, major depression, and bipolar disorder.

OR

- Oophorectomy when medically necessary (usually with hysterectomy and salpingectomy) and when **ALL** of the following are met:
  iv. Two referral letters from mental health professionals who have independently assessed patient, one of whom is acting in a purely evaluative capacity (not involved in long-term care), with each letter attesting to **ALL** of the following:
    - Member has a documented diagnosis of persistent gender dysphoria; **AND**
    - Member has an understanding of potential risks, harms, and irreversibility of procedure; **AND**
    - Member has full decision-making capacity to give fully informed consent; **AND**
    - There is documented appropriateness for the proposed surgery (e.g., clinical rationale supporting the request for surgery); **AND**
    - Appropriate psychosocial assessment confirms that comorbid mental health issues are absent or under control. This includes, but is not limited to, substance abuse, major depression, and bipolar disorder.
  v. Member has undergone at least 12 months of continuous hormone therapy consistent with gender dysphoria treatment goals (e.g., testosterone) or reason for contraindication, as documented by a Provider (e.g., endocrinologist, primary care).

OR

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- Genital Reconstructive Surgery (e.g., vaginectomy, metoidioplasty, scrotoplasty, phalloplasty, urethroplasty, placement of testicular prosthesis)
  i. Two referral letters from mental health professionals who have independently assessed patient, one of whom is acting in a purely evaluative capacity (not involved in long-term care), with each letter attesting to **ALL** of the following:
     - Member has a documented diagnosis of persistent gender dysphoria; **AND**
     - Member has an understanding of potential risks, harms, and irreversibility of procedure; **AND**
     - Member has full decision-making capacity to give fully informed consent; **AND**
     - There is documented appropriateness for the proposed surgery (e.g., clinical rationale supporting the request for surgery); **AND**
     - Appropriate psychosocial assessment confirms that comorbid mental health issues are absent or under control. This includes, but is not limited to, substance abuse, major depression, and bipolar disorder.

  ii. Member has undergone at least 12 months of continuous hormone therapy consistent with gender dysphoria treatment goals (e.g., testosterone) or reason for contraindication, as documented by a Provider (e.g., endocrinologist, primary care).
  iii. Documentation that the Member has lived in the gender role consistent with their gender identity for at least 12 months.

OR

- Voice Disorders when the Member meets **ALL** of the following:
  i. Diagnosis of voice disorder; **AND**
  ii. Evidence of voice-gender incongruence (if the Member is undergoing voice rehabilitation).

- Breast Reconstruction**; OR**
- Electrolysis (when required for phalloplasty)**; OR**
- Hysterectomy**; OR**
- Salpingo-oophorectomy**; OR**
- Vulvectomy.

c. Members undergoing **reconstructive chest surgery** (e.g., initial mastectomy, breast augmentation) must have **ONE** letter of recommendation from a qualified behavioral health Provider.

NOTE: Certain post-mastectomy services related to breast reconstruction and treatment of physical complications from mastectomy including nipple-areola reconstruction may be covered by the Women's Health and Cancer Rights Act (WHCRA), 29 U.S. Code § 1185b.

d. Members undergoing **hysterectomy, salpingo-oophorectomy, orchiectomy** must have documentation of:
- At least 12 months of continuous hormonal sex reassignment therapy; **AND**
- Two (2) recommendations for gender reassignment surgery by qualified mental health providers must be submitted to the surgeon performing the genital surgery.

e. Members undergoing **reconstructive genital surgery** must have the following:
- Documentation of at least 12 months of continuous hormonal sex reassignment therapy; **AND**
- Recommendation for surgery by two qualified mental health professionals; documentation must be submitted to the surgeon performing surgery. (If the first referral is from the Member's psychotherapist, the second referral should be from an individual who has had only an evaluative role with the Member); **AND**
- Documentation that the Member has lived for at least 12 continuous months in a gender role that corresponds with their gender identity.

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Additional Services

The following **may be considered medically necessary** for Members undergoing gender affirming procedures:

1. *Behavioral Health.* Services including, but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression).
2. *Hormonal Therapy.* This includes, but is not limited to: androgens, anti-androgens, GnRH analogues*, estrogens, and progestins. Prior authorization requirements may apply. Please reference *Pharmacy PA Criteria: Gender Dysphoria Hormone Therapy (Policy Number C17908-A).*
3. *Laboratory Testing.* For the monitoring of prescribed hormonal therapy.
4. *Age-Related, Gender-Specific Services.* This includes but is not limited to preventive health (as applicable to the Member's biological anatomy such as cancer screenings [e.g., cervical, breast, prostate]) and treatment of the prostate.

Limitations

Medicaid defines cosmetic surgery as services that are intended primarily to change or improve a Member's physical appearance that would be considered within a normal anatomic variation and **are not covered.** The following procedures and services for the treatment of gender dysphoria may be considered cosmetic and not covered – this includes, but is not limited to: Please check State mandates and health plan regulations regarding coverage and exclusions for cosmetic services. Mandates and/or regulations supersede this policy. The following procedures and services for the treatment of gender dysphoria **may be considered cosmetic and/or not medically necessary**, including but not limited to:

- Blepharoplasty – removal of redundant skin of upper and/or lower eyelids and protruding periorbital fat
- Chin Augmentation
- Collagen Injections
- Cricothyroid Approximation – voice modification that raises the vocal pitch by simulating contractions of the cricothyroid muscle with sutures
- Facial Feminizing Procedures
- Hair Removal / Hair Transplantation (e.g., electrolysis, laser hair removal)**
- Laryngoplasty – reshaping of laryngeal framework (voice modification surgery)
- Liposuction – removal of fat
- Lip Enhancement, Reduction, Lift and Lip Filling
- Mastopexy – breast lift
- Rhinoplasty – reshaping of nose
- Trachea Shave / Reduction Thyroid Chondroplasty – reduction of the thyroid cartilage

** Electrolysis or laser hair removal sessions may be considered medically necessary for skin graft preparation for genital surgery.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

[1]Oles et al. (2022) performed the first systematic review of available gender-affirming surgery publications (including all procedures) to analyze outcomes reported in the literature as well as methods used for outcome assessment. While some procedures have been long performed, data is limited for each and requires a review of the literature to understand current knowledge and to steer needed future research. The systematic review was conducted following

Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines to identify all outcomes measures gender-affirming surgery cohorts. In total, 15,186 references were identified, 4162 papers advanced to abstract review, and 1826 underwent full-text review; upon review, there were 406 cohort publications. Of non-genitoplasty titles, 35 were mastectomy, 6 mammoplasty, 21 facial feminization, and 31 voice/cartilage. Although 59% of non-genitoplasty papers addressed PCOs in some form, only 4.3% used instruments partially validated in transgender patients. Overall, data were reported heterogeneously and were biased towards high-volume centers. The authors present a comprehensive list of outcome instruments which offers an ideal starting basis for discussions between patients and providers regarding deficiencies that require attention. In addition, consistent use of the same outcome measures and validated gender-affirming surgery-specific instruments are needed as they represent two primary barriers to high-quality research where improvement efforts should be focused.

[2]Oles et al. (2022) also performed a systematic review focusing on genital reconstruction. Gender affirming surgery results were analyzed in a multidimensional way, involving complication rates and anatomic (e.g., vaginal depth), functional (e.g., urinary), and psychosocial outcomes. Of the total references identified (as noted above), there were 406 GAS cohort publications (171 vaginoplasty, 82 phalloplasty, 16 metoidioplasty, 23 oophorectomy/vaginectomy, and 21 with multiple procedures). Although 69% of genitoplasty papers addressed patient-centered outcomes, only 1% used metrics validated in the transgender population. Forty-three different outcome instruments were used. No instrument was used in more than 15% of published series and 38 were used in only one or two publications. Overall, the review identified high patient satisfaction for genital procedures however there was little concordance between study methods – nearly 90% of patient-focused outcome metrics appeared once or twice. The authors suggest standardization of outcome instruments and measurement methods by taking a patient-inclusive, multidisciplinary approach to improve quality of care.

Akhavan et al. (2021) analyzed data from the literature that were specific to gender-affirming mastectomies, vaginoplasty, vulvaplasty, mastectomy, metoidioplasty, and phalloplasty. The review found that gender affirmation surgery is generally safe and complication rates are low for gender-affirming mastectomy and breast augmentation; complication rates for genital surgeries are also considerable low. Surgery can decrease rates of gender dysphoria, depression, and suicidality as well as greatly improve quality-of-life measures. Gaps exist in the research with respect to female-to-male surgery as well as surgical complication rates for genital surgery, facial masculinization and feminization, and patient-reported outcomes.

Almazan et al. (2021) evaluated associations between gender affirming surgeries and mental health outcomes (e.g., psychological distress, substance use, and suicide risk). A secondary analysis of data was conducted from the 2015 U.S. Transgender Survey, which includes the largest existing data set across the 50 states and Washington, D.C. The focus of the survey is on the surgical and mental health experiences of transgender individuals. Data of the 27,715 adults that participated in 2015 were analyzed between November 1, 2020, and January 3, 2021.Over 12% (3559 participants) endorsed undergoing one or more types of gender affirming surgery at least two years prior to submitting survey responses; almost 60% (16,401 participants) endorsed a desire to undergo one or more types of gender affirming surgery but denied undergoing any of these. Upon adjusting the data for sociodemographic factors and exposure to other types of gender-affirming care, undergoing one or more types of gender affirming surgery was associated with lower past-month psychological distress, past-year smoking, and past-year suicidal ideation.

Eftekhar et al. (2020) conducted a systematic review and meta-analysis on the quality of life (QoL) of the transgender population post transsexual surgery. Of the nearly 500 articles initially identified (published through December 2019), eight articles were selected for meta-analysis – this included 1099 patients. The mean of QoL in transgender individuals was 70.45 based on World Health Organization Quality of Life (WHOQoL-BREF) and The 36-item short form of the Medical Outcomes Study questionnaire (SF36). Further analysis indicated that the weighted mean QoL in male to female and female to male indicate that the mean QoL in female to male was 57.54 and 62.47 in male to female (based on SF36 questionnaire). The weighted mean QoL in female to male was 69.99 and 70.65 in male to female (based on WHOQoL-BREF questionnaire). Analysis results support approaches to gender reassignment.

Weinforth et al. (2019) performed a systematic literature to assess the available date on QoL following male-to-female reassignment surgery. A total of 13 articles (1101 study participants) were reviewed; the number of trans women in each study ranged from 3 to 247 and had a mean age of 39.9 years (range of 18-76). Seven questionnaires were utilized used to analyze participants QoL following surgery. Results show that gender reassignment surgery benefits emotional well- being, sexuality, and general QoL. In addition, participants reported "freedom from pain", "fitness", and

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"energy". Some studies identified worsening in some patients following surgery however, overall improved QoL was reported.

Chest Surgery

Cohen et al. (2019) performed a literature review using PubMed for articles related to patients who were transgender female to male. Often, chest contouring is the first surgery that patients undergo and helps individuals assimilate into their new gender role. While there are different techniques to create an aesthetic male chest, it requires adjustment of breast tissue volume, proper nipple-areolar complex placement, and abolishment of the inframammary fold. Consensus on the preferred technique is varied. The authors identified 67 unique articles – 22 met inclusion criteria; 2447 unique patients were analyzed. The authors found that further research is needed with respect to patient selection, surgical decision making, and patient-reported outcomes for various chest contouring techniques. Specific research is needed regarding the ideal nipple-areolar complex shape, size, and location.

Tolstrup et al. (2020) performed a systemic comprehensive literature review using PubMed, EMBASE, CINAHL, PsycINFO, Scopus and the Cochrane Library to identify studies that evaluated gender-confirming chest surgery in a non-cis gender population. Outcome measures were reviewed. A total of 849 records were found; 47 were included in the review. Feminizing gender-confirming chest surgery was analyzed in 11 studies while masculinizing gender-confirming chest surgery was evaluated in 39 studies. Categories of patient-reported outcomes were used in 29 studies and included aesthetic outcome, functional outcome and mental health parameters. In conclusion, the summary of outcome domains and classifications found large variations in outcome evaluation between studies. While several studies reported on similar outcome categories, there was a high level of heterogeneity of domains and classifications of outcomes. Future research should focus on the evaluation of outcomes with an effort to streamline reporting and compare surgical outcomes between studies.

Genital Surgery

Nassiri et al. (2020) performed a systematic review to evaluate the effect of gender reassignment surgery on the development of urethral complication. A total of 879 articles published up until June 2019 were included and identified the Pubmed, Scopus, Embase, and Web of Science databases. Following examination and removal of articles that were not pertinent to the review, 32 studies were examined which included a total of 3463 patients. Female-to-male (FtM) surgery and male-to-female (MtF) surgery was discussed in 23 and 10 studies, respectively (one study discussed both). Differing patterns of complications were observed in FtM and MtF surgeries; increased complications were noted FtM surgeries due to the larger size of the neourethra. Complications related to meatal stenosis (a concern in MtF surgery) ranged from 4 to 40%; meatotomy for repair was often required. Stricture and fistulization are often reported complications following FtM surgery; studies reporting on fistulae involving the urethra found that 19 to 54% of fistulae resolved spontaneously without further surgical intervention. The authors concluded that high rates of complications are reported in the medical literature which emphasizes the need for proper patient education regarding risks and benefits of surgery.

Rooker et al. (2019) conducted a comprehensive literature review to analyze and aggregate reported characteristics and outcomes of penile prosthesis implantation in the trans masculine patient. Penile prostheses are often used to achieve erectile rigidity after phalloplasty in trans masculine patients. Due to the delicate nature of the neophallus and lack of native erectile tissue, complications and challenges are of concern. While novel phalloplasty and prosthesis insertion techniques have been developed, none have proven superior. The authors used the Medline, EMBASE, and Cochrane Registry databases; articles through February 2019 were included. Studies included and analyzed those prosthesis outcomes in patients who received a neophallus as part of a gender-affirming procedure. A total of 23 journal articles (retrospective or case series/reports) were reviewed – this included 1,056 patients who underwent phalloplasty and 792 who received a penile prosthesis. Over 83% of the prostheses were inflatable versus 16% were non-inflatable. The number of cylinders used for each prosthesis was 61% (single-cylinder) and 39% (double-cylinder). Follow-up duration had a mean of 3.0 years. Complications were reported by 36% of patients who received a prosthesis; at follow-up 60% of patients had their original implant present and 84% reported achieving penetration. While prosthesis implantation in gender-affirming operations may pose a significant risk of complication, this is a reasonable and useful method to achieve rigidity necessary for sexual intercourse.

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Massie et al. (2018) performed a retrospective chart review of a single surgeon's experience with penile inversion vaginoplasty (performed from July 2014 to June 2016). Information analyzed included patient demographic data, postoperative complications, and patient-reported outcome data. The data were correlated by binary logistic regression to identify predictors of postoperative complications and patient satisfaction. Penile inversion vaginoplasty is the current gold standard procedure for MtF transgender patients undergoing gender-confirming genital surgery. While data concerning complications have been extensively reported in the medical literature, studies regarding patient-reported outcomes are limited. The aim of the study was to report postoperative complications and patient-reported outcomes based on the largest cohort in the United States undergoing penile inversion vaginoplasty. A total of 117 patients underwent penile inversion vaginoplasty. Common complications included granulation tissue (26%), intravaginal scarring (20%), and prolonged pain (20%). A majority of patients (94%) reported that they felt positive about their genitals and would have the surgery again. Over 70% of patients reported resolution of their gender dysphoria. Predictors of patient dissatisfaction included intravaginal scarring, prolonged pain, excessive external scarring, loss of sensation, and hematoma/excessive bleeding. Regardless of the moderate complication risks, patient satisfaction is very high following penile inversion vaginoplasty.

Studies and Trials

There are no randomized controlled trials evaluating the effectiveness of surgical treatment of gender dysphoria (GD). Available evidence consists of cohort studies comparing outcomes in patients that underwent sex reassignment surgery (SRS) versus transgendered patients that had not undergone SRS and cross sectional studies that compared outcomes in either transgendered patients who had undergone SRS versus those who had not undergone SRS. The majority of the studies did not explicitly state inclusion and exclusion criteria. Sample sizes ranged from 35 to 376 patients. Follow-up time since SRS varied widely across studies and ranged from one month to seven years. There is insufficient evidence to establish definitive patient selection criteria for SRS to treat GD. Professional groups recommend that SRS be restricted to individuals who are referred for sex reassignment services by a qualified behavioral health professional, and that while one referral is sufficient for breast or chest surgery, two independent referrals should be required for genital SRS. Individuals who have medical contraindications to surgery should not undergo SRS. (Heylens et al., 2014; Weigert et al., 2013; Berry et al., 2012; Motmans et al., 2012; Dhejne et al., 2011; Ainsworth & Spiegel, 2010).

There are no randomized controlled trials evaluating the effectiveness of hormone treatment for gender dysphoria. Available evidence consists of cross-sectional studies where a group of transgender individuals, some of whom had undergone cross-sex hormone therapy and some of whom had not, responded to questionnaires. Sample sizes in these studies of adults ranged from 50 to 376. The studies most commonly evaluated quality of life (QOL) or functional status with instruments such as the SF-36 Health Survey (QualityMetric Inc.), mood-related conditions such as depression or anxiety, and/or psychosocial conditions such as perceived social support or partnership status. A variety of other behavioral and social outcomes were each assessed and results were generally positive. (Colizzi et al., 2014; Fisher et al., 2014; Costantino et al., 2013; Gorin-Lazard et al., 2013; Wierckx et al., 2013; Gorin-Lazard et al., 2012). A systematic review based on 28 studies (1833 participants; 1091 MtF and 801 FtM) published from 1996 to February 2008 included a meta-analysis of the QOL and psychosocial outcomes of hormone therapy. 80% of the study participants reported significant improvement in quality of life and reported significant improvement in psychiatric symptoms. (Murad et al., 2010).

Children and Adolescents

The American Academy of Child and Adolescent Psychiatry (AACAP) posted a literature review conducted on gender dysphoria in childhood and adolescence.

- Aitken et al. (2016) examines self-harm, suicidal ideation, and suicidal behavior (by parent report). Children with gender dysphoria show an increase in self-harm and suicidality as age progressed.
- Dheine et al. (2016) provides an overview of existing studies on psychiatric disorders in transgender patients. This population has an increased risk of psychiatric morbidity however, symptoms improve with gender affirming care and mental health care.
- Durwood et al. (2017) researchers of the TransYouth Project analyzed depression, anxiety, and self-worth in children age 9-14 who had socially transitioned. Results showed that transgender children had similar rates of

depression and marginally higher rates of anxiety.
- Olson et al. (2016) examined depression and anxiety in transgender children who have socially transitioned. Research showed that when support was received for their gender identities, normative rates of depression were found as well as decreased anxiety.

National and Specialty Organizations

World Professional Association for Transgender Health (WPATH)

Since 1979, WPATH has published the internationally accepted *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. (An update is expected by WPATH in 2022 including new chapters on Education, Ethics, Eunuchs, Non-Binary, and Sexual Health. This policy will be updated once the update is published). The overall purpose of the Standards is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieve lasting comfort with their gendered selves. In turn, this will maximize an individual's overall health, psychological well-being, and self-fulfillment. Assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments (2017). Sections include:

- Purpose and Use of the Standards of Care
- Global Applicability of the Standards of Care
- The Difference Between Gender Nonconformity and Gender Dysphoria
- Epidemiologic Considerations
- Overview of Therapeutic Approaches for Gender Dysphoria
- Assessment and Treatment of Children and Adolescents with Gender Dysphoria
- Mental Health
- Hormone Therapy
- Reproductive Health
- Voice and Communication Therapy
- Surgery
- Postoperative Care and Follow-Up
- Lifelong Preventive and Primary Care
- Applicability of the Standards of Care to People Living in Institutional Environments
- Applicability of the Standards of Care to People with Disorders of Sex Development
- Appendices include a Glossary; Overview of Medical Risks of Hormone Therapy; Summary of Criteria for Hormone Therapy and Surgeries; Evidence for Clinical Outcomes of Therapeutic Approaches; and Development Process for the Standards of Care.

For the male-to-female (MtF) patient, surgical procedures may include the following:
- Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
- Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
- Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:
- Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
- Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;
- Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

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American Academy of Child and Adolescent Psychiatry (AACAP). Practice principles published by AACAP (Adelson & AACAP, 2012) address issues faced by children and adolescents who identify as gay, lesbian, bisexual, gender nonconforming, or gender discordant. The following principles focus on cultural competence, research needs, and ethics:

1. **Principle 1.** All children and adolescents should complete a comprehensive diagnostic evaluation that is age-appropriate and assesses their psychosexual development.
2. **Principle 2.** Confidentiality must be upheld when assessing sexual and gender minority youth.
3. **Principle 3.** With respect to the individual's sexual orientation, gender nonconformity, and gender identity, family dynamics should be assessed as they relate to cultural values of the individual, their family, and community.
4. **Principle 4.** Providers should assess the individual for commonly encountered situations by this population that can increase the risk of psychiatric diagnoses.
5. **Principle 5.** Providers should focus on establishing healthy psychosexual development in sexual and gender minority youth. This includes protecting their full capacity for identity formation and adaptive functioning.
6. **Principle 6.** Providers should understand that evidence does not exist that one's sexual orientation can be altered via therapy (and that such attempts may be harmful).
7. **Principle 7.** Providers should be aware of current literature supporting the natural course of gender discordance and associated psychopathology and how it impacts the selection of treatment goals and modalities.
8. **Principle 8.** Providers should be available as a liaison with schools, community agencies, and other health care providers to advocate for the unique needs of this population and their families.
9. **Principle 9.** Mental health providers should be knowledgeable of community and professional resources for sexual and gender minority youth.

American Academy of Pediatrics (AAP). The AAP (2021) published a policy statement on *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth.* The AAP notes that pediatricians should provide factual, current, nonjudgmental information in a confidential manner to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. Particular attention should also be paid to the effects of homophobia and heterosexism that can contribute to increased mental health issues for sexual minority youth. Providers should acknowledge and affirm their patient's feelings of gender dysphoria; referral to a qualified mental health professional is vital to assist the patient as well as educate them and assess their readiness for transition. Those who receive the right assistance and care are more likely to live a healthy, productive life as they go through adolescence and enter young adulthood. The AAP (2018) also published a policy statement on *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents.* Highlights include the need for more formal training, standardized treatment and research that focuses on safety and medical outcomes.

American College of Obstetricians and Gynecologists (ACOG). A Committee Opinion was published by ACOG (2021) to provide clinical guidance to obstetrician–gynecologists caring for transmasculine and transfeminine patients to offer inclusive patient care. In addition, ACOG notes that most medications used for gender transition are common and can be safely prescribed by a variety of health care professionals when given proper appropriate training and education. This includes, but is not limited to, obstetrician–gynecologists, family or internal medicine physicians, endocrinologists, psychiatrists, and advanced practice clinicians. Additional recommendations include discussion of fertility and parenting desires, prior to starting hormone therapy or gender affirmation surgery. Patients should also know that gender-affirming hormone therapy is not effective contraception; sexually active individuals should be educated about contraceptive options if they do not wish to become pregnant or cause pregnancy in others. Finally, to lead preventive medical care, any anatomical structure present that warrants screening should be screened, regardless of the patient's gender identity.

Endocrine Society. The **Endocrine Society** (2009) published a clinical practice guideline titled *Endocrine Treatment of Transsexual Persons* which focuses on gender dysphoria and provides a standard of care for supporting transgender individuals. Recommendations include evidence that treatment of gender dysphoria is medically necessary. Sections include:

1. Diagnostic Procedure
2. Treatment of Adolescents

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3. Hormonal Therapy for Transsexual Adults
4. Adverse Outcome Prevention and Long-Term Care
5. Surgery for Sex Reassignment

Society for Adolescent Health and Medicine (SAHM). The **SAHM** (2020) encourages Providers treating adolescent and young adults to receive training in providing culturally effective, evidence-based care for transgender youth. The SAHM states that additional research on gender-affirming health care is needed and advocates for policies that protect the rights of transgender youth to limit barriers to healthcare. The SAHM aligns with other professional organizations and promotes the call for gender affirmation as a mainstay of treatment and is opposed to the notion that diversity in gender is pathological.

SUPPLEMENTAL INFORMATION

The following are terms related to gender care (Perzanowski et al., 2020; Rafferty et al., 2018).

Term	Definition
Affirmed Gender	When one's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic
Agender	A term that is used to describe one who does not identify as having a particular gender.
Cisgender	Used to describe an individual who identifies and expresses a gender that is consistent with the culturally defined norms of the sex they were assigned at birth.
FTM (affirmed male; trans male)	Used to describe individuals who were assigned female sex at birth but who have a gender identity and/or expression that is asserted to be more masculine.
Gender Dysphoria	A concept designated in the DSM-5 as clinically significant distress or impairment related to a strong desire to be of another gender, which may include desire to change primary and/or secondary sex characteristics. Not all transgender or gender diverse people experience dysphoria.
Gender Expression	The external way an individual expresses their gender (e.g., clothing, hair, mannerisms, voice/speech patterns, activities, or social roles).
Gender Identity	An individual's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations.
Gender Identity Disorder	A psychiatric diagnosis (previously defined in the *DSM-IV* that was changed to "gender dysphoria" in the *DSM-5*). Primary criteria include a strong, persistent cross-sex identification and significant distress and social impairment. This diagnosis is no longer appropriate for use and may lead to stigma – the term may be found in older research.
Gender Perception	How others interpret a person's gender expression.
Gender Diverse	An umbrella term to describe individuals with gender identities and/or expressions that vary from expected developmental norms; includes individuals who identify as multiple genders or with no gender at all.
MTF (affirmed female; trans female)	Used to described individuals who were assigned male sex at birth but who have a gender identity and/or expression that is asserted to be more feminine.
Nonbinary	Individuals whose gender identity is neither girl/woman nor boy/man.
Sex	Assignment made at birth, usually male or female, based on external genital anatomy; may be based on internal gonads, chromosomes, or hormone levels.
Sexual Orientation	Describes the types of individuals toward whom a person has emotional, physical, and/or romantic attachments.
Transgender	An umbrella term describing individuals whose gender identity does not align in a traditional sense with the gender they were assigned at birth. It may also be used to refer to a person whose gender identity is binary and not traditionally associated with that assigned at birth.

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The following are terms related to diagnoses (Garg et al., 2021):

Other Specified Gender Dysphoria applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The "other specified gender dysphoria" category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for gender dysphoria. This is done by recording “other specified gender dysphoria” followed by the specific reason (e.g., “brief" gender dysphoria).

Unspecified Gender Dysphoria applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The "unspecified gender dysphoria" category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for gender dysphoria and includes presentations in which there is insufficient information to make a more specific diagnosis.

Differential Diagnoses for gender dysphoria include: autogynephilia; body dysmorphic disorder; gynandromorphophilia; intersex states; psychosis; paraphilic disorders; self-amputation; schizophrenia; and transvestitism.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
55970	Intersex surgery; male to female
19325	Mammaplasty, augmentation; with prosthetic implant
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
55980	Intersex surgery; female to male
19303	Mastectomy, simple, complete
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple

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55180	Scrotoplasty; complicated
56625	Vulvectomy simple; complete
57106	Vaginectomy, partial removal of vaginal wall
57110	Vaginectomy, complete removal of vaginal wall
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

The following CPT codes may be considered Cosmetic Procedures and non-covered:

Blepharoplasty	
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
Body Contouring	
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (list separately in addition to code for primary procedure
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (list separately in addition to code for primary procedure)
Breast Lift and Reconstruction	
19316	Mastopexy

19350	Nipple/areola reconstruction
Brow Lift	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
Calf Implant	
27656	Repair, fascial defect of leg
Cheek, Malar, Pectoral Implant	
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
Chin/Nose Implants, Chin Recontouring	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
Collagen Injections	
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
Dermabrasion and Peels	
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
Face and Neck Tightening	
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
Facial Bone Reduction	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Forehead Reduction and Contouring	
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
Hair Removal	
17380	Electrolysis epilation, each 30 minutes
Hair Transplant	
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
Jaw Reduction, Contouring, Augmentation	
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
Laryngoplasty	
31599	Unlisted procedure, larynx

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Lip Lift and Lip Filling	
40799	Unlisted procedure, lips
Liposuction-Lipectomy	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
Rhinoplasty	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
Thyroid Reduction Chondroplasty	
31750	Tracheoplasty; cervical
Voice Modification	
31899	Unlisted procedure, trachea, bronchi

HCPCS Codes – None.

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APPROVAL HISTORY

4/13/2022 New policy.

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APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.* States can delete items from other States that do not apply.

Gender Dysphoria Coverage

FLORIDA, ILLINOIS, KENTUCKY, MICHIGAN, MISSISSIPPI, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, WASHINGTON, WISCONSIN: Molina and Passport cover the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria.

Transgender Surgery Coverage

CALIFORNIA, FLORIDA, IDAHO, ILLINOIS, MICHIGAN, MISSISSIPPI, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, WASHINGTON, WISCONSIN: Molina covers if the request is determined via DSM V and any additional criteria that the Medical Management Team requires(in compliance with Federal Law).

Non-Covered Procedures and Services

Hair Loss of Growth Treatment

CALIFORNIA: Items and services for the promotion, prevention, or other treatment of hair loss or hair growth are not covered. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

FLORIDA, IDAHO, ILLINOIS, KENTUCKY, MICHIGAN, MISSISSIPPI, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, WASHINGTON, WISCONSIN: Items and services for the promotion, prevention, or other treatment of hair loss or hair growth are not covered.

Additional State Information

CALIFORNIA

Molina covers medically necessary treatment of a mental health or substance use disorder, including services for the treatment of gender dysphoria, only when that disorder is listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

CA Health and Safety Code, Article 5. Standards 1367.042
CA Health and Safety Code, Solicitation and Enrollment, Section 1365.5
DMHC Director's Letter 12-K "Gender Non-Discrimination Requirements"
DMHC All Plan Letter: Health and Safety Code Section 1365.5 Compliance

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IDAHO

Molina covers inpatient and outpatient Mental Health Services. Except for involuntary admissions, all inpatient admissions, and certain outpatient services require Prior Authorization. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria.

KENTUCKY

Passport covers if the request is determined via criteria that the Medical Management Team requires.

NEW MEXICO

State of New Mexico Senate Bill 317: Applying Cost-Sharing Waivers to Behavioral Health Service

NOTE: Behavioral Health, or Substance Abuse drugs subject to Senate Bill 317 are at no charge (see 2022 NM EOC)

For transgender people, preventive services will not be limited based on an individual's sex assigned at birth, gender identity or recorded gender. Coverage and claims will not be denied or limited or subject to additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Molina covers all medically necessary benefits and services outlined in this Agreement.

WASHINGTON

Effective June 25, 2014 – Washington Office of the Insurance Commissioner, Commissioner's Letter Gender Identity Non-Discrimination Requirements

WAC 284-43-5622 Plan Design

A health benefit plan must not be offered if the commissioner determines that:

a. It creates a risk of biased selection based on health status;
b. The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful health benefit; or
c. The benefit has a discriminatory effect in practice, outcome or purpose in relation to age, present or predicted disability, and expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity or in the application of Section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008).

WSR 21-20-110 CR-103P (Implements RCW 34.05.360) (October 2017)

WAC 284-43-5150 – Unfair Practice Relating to Health Coverage

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