PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 01/10/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3039 - Direct Members
C. MCUP3114 - Physical, Occupational and Speech Therapies
D. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Gender Dysphoria is a formal diagnosis used by psychologists and physicians to describe persons who experience significant dysphoria, describing the emotional distress over a marked incongruence between one's experienced/expressed gender and assigned gender. These individuals are commonly referred to as transgender or gender nonconforming (TGNC).
B. Medical Necessity (Age 21 and over): As defined per Partnership HealthPlan of California's (PHC's) contract with the Department of Health Care Services (DHCS), medically necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Medical Necessity (Under Age 21): In addition to the definition noted in III. B above, medical necessity for members under age 21 is also defined as services necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by the screening services (per Section 1396d(r)(5) of Title 42 of the United States Code)
D. Medi-Cal Rx: The program title established by the State of California Department of Health Care Services (DHCS) for the new system of administering Medi-Cal pharmacy benefits through the fee-for-service (FFS) delivery system effective January 1, 2022.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the criteria and process by which Partnership HealthPlan of California (PHC) will provide benefits for the surgical treatment of gender dysphoria.

VI. POLICY / PROCEDURE:

A. A Treatment Authorization Request (TAR) is required for all procedures related to gender dysphoria and

shall be reviewed on a case-by-case basis.

B. Continuity of care requests will be reviewed by the PHC Medical Director or Physician Designee for medical necessity and continued care. There must be a clearly established relationship with the provider and the willingness of the provider to continue care.

C. When reviewing a request for the surgical treatment of gender dysphoria, Partnership HealthPlan of California utilizes the most recent criteria as outlined by the World Professional Association for Transgender Health (WPATH) and as defined as a covered benefit according to the All Plan Letter (APL) 20-018 issued by the California Department of Health Care Services (DHCS). All requests will be reviewed by the Chief Medical Officer or Physician Designee for medical necessity.
    1. According to the APL 20-018 (excerpted):
        a. Managed care health plans (MCPs) must also provide reconstructive surgery to all Medi-Cal beneficiaries, including transgender or gender nonconforming beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body, to create a normal appearance to the extent possible" and for transgender members, may consider gender dysphoria as a developmental abnormality. In the case of transgender or gender nonconforming beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.
        b. MCPs are not required to cover cosmetic surgery. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance."
    2. Gender reassignment/ affirming surgery is a covered benefit according to APL 20-018 and will be reviewed according to most recent WPATH criteria for the surgery. The requesting provider must submit evidence in demonstration of meeting either medical necessity or reconstructive surgery criteria consistent with WPATH criteria. This may include, but is not limited to:
        a. Persistent, well-documented gender dysphoria
        b. Capacity to make a fully informed decision and consent for treatment
        c. Consent for gender reassignment/ affirming surgery must be in compliance with current California consent policies and statutes.
        d. An assessment of the member by qualified mental health professionals within the past year that is in agreement with the surgery.
            1) If significant medical or mental health concerns are present, they must be reasonably well controlled
        e. Documented collaboration with, and agreement to, surgery by the beneficiary's primary care provider or provider of transgender or gender nonconforming care
        f. The list of surgical procedures may include:
            1) For Male to Female (MtF, also known as transfeminine) patients or gender nonconforming patients desiring surgery for de-masculinization
                a) Breast / chest surgery: augmentation mammoplasty (implants / lipofilling)
                b) Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty
            2) For Female to Male (FtM, also known as transmasculine) patients or gender nonconforming patients desiring surgery for de-feminization
                a) Breast/ chest surgery: subcutaneous mastectomy, creation of a male chest (excluding pectoral implants)
                b) Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses.
        g. It is suggested that health care professionals consider gender-affirming genital procedures in eligible transgender and gender diverse adults seeking these interventions when there is evidence the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired

surgical result unless hormone therapy is either not desired or is medically contraindicated).

h. Specific considerations: PHC does not categorically limit any services or the frequency of services available to a transgender or gender nonconforming member, however, the following services are evaluated using the criteria stated below:
   1) For mastectomy and creation of a male chest – no hormone therapy is required.
   2) For breast augmentation – hormone therapy may be required to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated.
   3) For hysterectomy, oophorectomy, salpingo-oophorectomy and for orchiectomy – hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated, not desired, or are contraindicated for the individual) – to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention. Other surgery specific preauthorization criteria must be met.
   4) For metoidioplasty or phalloplasty (including testicular prostheses) and for vaginoplasty:
      a) Hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated, not desired, or are contraindicated for the individual).
      b) 12 continuous months of living in a gender role that is congruent with the patient's identity as documented by the member's primary care provider (PCP) or transgender care clinician. Exceptions can be made if there are safety considerations for the patient.
   5) Non-genital, Non-breast surgery or treatments that may be considered non-reconstructive and may be considered cosmetic surgery and therefore not a covered benefit will be considered on a case by case basis including: facial feminization surgery, thyroid cartilage reduction, hair reconstruction/removal.
   6) Prior to any pitch changing surgery, speech therapy as conversational therapy should be considered, and for FtM, hormone therapy should be included. Voice training should be part of a comprehensive program to develop either feminine or masculine communication that goes beyond change in pitch to also include intonation, resonance, intensity, syntax, rate of speech, vocabulary, and non-vocal communication. The member must be able to achieve stimulable conversation. (See also policy MCUP3114 Physical, Occupational and Speech Therapies)
   7) Rhinoplasty may be considered using the guidelines noted in Section VI.C.1.a. and b. above. In order to determine medical necessity, submit the following information:
      a) Photos of the member's face and nose (two views) are required.
   8) Liposuction, lipofilling (with the exception of breast augmentation), gluteal augmentation (implants/liposuction/lipofilling), facelift, facial lip augmentation/ reduction, and blepharoplasty are evaluated on a case by case basis based on the principles listed in Section VI.C.1. above.
   9) Repeat reconstructive surgery in the absence of physiologic dysfunction (e.g. second breast enhancement) may be considered cosmetic and if so, not a benefit.
   10) Gender nonconforming surgical requests will be reviewed on a case by case basis.

3. Pharmaceutical treatment for gender dysphoria: Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter (APL) 22-012, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/Magellan instead of PHC. This includes medications used for the treatment of gender dysphoria. Refer to the PHC website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx The State Medi-Cal Contract Drug List (CDL) can be found in both the Medical and Pharmacy provider manual sections of the website at https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx?t=4

D. Treatment Authorization Review (TAR)
   1. TARs must be submitted prior to any surgical procedure referenced in section VI.C.2.f and demonstrate either medical necessity or reconstructive surgery criteria that is consistent with

WPATH criteria as described in section C.2.

2. Requests received will be forwarded to the Chief Medical Officer or Physician Designee for review and determination. Requests for surgical treatment of gender dysphoria shall be reviewed for reconstructive surgery criteria, the standard of care as advised by WPATH, and medical necessity requirements.
   a. Review of reconstructive surgery criteria and medical necessity are considered separate and distinct and may independently serve as the basis for approval of a request.
   b. Where medical necessity is not met, PHC must review the TAR to determine if criteria for reconstructive surgery is met, taking into consideration the gender with which the member identifies.
   c. Denial of a TAR, in whole or part, must describe the basis for denial for both reconstructive surgery criteria and medical necessity.

E. Claims Submission
   1. Intersex surgery should not be requested or billed using CPT code 55970 (intersex surgery; male to female) or CPT code 55980 (intersex surgery; female to male). Due to the serial nature of surgery for the gender transition, CPT coding should be specific for the procedures performed during each operation.

F. Statement of Non-Discrimination
   1. PHC does not discriminate against transgender individuals and treats beneficiaries in a manner consistent with their gender identity.
   2. PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose 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 or gender nonconforming 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 are exclusively available.
   3. PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

VII. REFERENCES:

A. World Professional Association for Transgender Health (WPATH) criteria, current version. https://www.wpath.org/publications/soc
B. DHCS All Plan Letter (APL) 20-018: Ensuring Access to Transgender Services (10/26/2020)
C. Title 45 Code of Federal Regulation (CFR) Sections 92.207 (b) (3) and (5)
D. Title 42 United States Code (USC) Section 1396d(r)(5)
E. Insurance Gender Nondiscrimination Act (IGNA) Health and Safety Code (HSC) Section 1365.5
F. DHCS APL 22-012 Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx. (07/11/2022)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 01/20/16; 02/15/17; 04/19/17; *06/13/18; 09/11/19; 09/09/20; 01/13/21; 09/08/21; 10/12/22; 01/10/24

Policy/Procedure Number: MCUP3125		Lead Department: Health Services
Policy/Procedure Title: Gender Dysphoria/Surgical Treatment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/21/2013	**Next Review Date: 01/10/2025** **Last Review Date: 01/10/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.