Policy Number: CP-IFP23-0033A Effective Date: January 1, 2024

Gender-Affirming Treatment

This coverage policy provides guidance for gender-affirming medical and/or surgical services that may be requested on behalf of transgender and gender-diverse individuals to better align their body with their gender identity.

DISCLAIMER

Coverage Policies are developed to assist in identifying coverage for UCare benefits under UCare's health plans. They are intended to serve only as a general reference regarding UCare's administration of health benefits and are not intended to address all issues related to coverage for health services provided to UCare members.

These services may or may not be covered by all UCare products (refer to product section of individual coverage policy for product-specific detail). Providers are encouraged to have their UCare patient refer to their UCare plan documents (Evidence of Coverage/Member Handbook/Member Contract) for specific coverage information. If there is a conflict between a coverage policy and the UCare plan documents, the UCare plan documents prevail.

Coverage Policies do not constitute medical advice. Providers are responsible for submission of accurate and compliant claims.

Product Summary

This coverage policy applies to the following UCare products:

UCare product	Applies to
UCare Individual & Family Plans (IFP), UCare IFP with M Health Fairview	✓
UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, UCare Advocate Plus (HMO I-SNP), EssentiaCare	
UCare's Minnesota Senior Health Options (MSHO) (HMO D-SNP)	
UCare Connect + Medicare (HMO D-SNP)	
UCare Connect (SNBC)	
Prepaid Medical Assistance Program (PMAP), MinnesotaCare	
Minnesota Senior Care Plus (MSC+)	

Benefit category:

The IFP member contract language states:

- Services that are ordinarily or exclusively available to members of one sex will not be denied to a transgender person based on the sex assigned at birth, gender identity, or if the gender otherwise recorded is different from one to which coverage is ordinarily and exclusively available.
- Exclusions-Services Not Covered
    - Gender-confirming surgical procedures that are not medically necessary or are primarily cosmetic.

Benefits for affirming services that are covered are determined by the type of care being rendered. Member cost share for applicable benefit categories applies as determined by the member contract.

- Durable Medical Equipment
- Hospital Inpatient Services
- Mental Health Outpatient Services, including Office Visits
- Office Visits Primary Care and Specialist Hospital Outpatient Care, Including Ambulatory Center, and Surgery Physician Services
- Prescription Drugs

Definitions or summary

Gender dysphoria is a diagnosis that refers to the clinically significant distress or impairment that may accompany the incongruence between one's experienced or expressed gender and one's sex assigned at birth which may include desire to change primary and/or secondary sex characteristics.

Terms associated with gender dysphoria diagnosis and related services

- Gender affirmation or confirmation surgery
- Gender reassignment surgery
- Transgender and gender diverse (TGD)
- Male to Female-MTF
- Female to Male- FTM

Treatment for gender dysphoria is part of a multi-disciplinary process involving multiple medical and surgical services.

- Hormone therapy
- Mental health services (e.g., counseling, psychotherapy)
- Primary care
- Specialty care (e.g., plastic surgery, gynecology, urology, reproductive medicine)
- Surgical procedures

Hormonal gender reassignment is the administration of androgens to genotypic and phenotypic females, and the administration of estrogen and/or progesterone to genotypic and phenotypic males, for the purpose of effecting somatic changes for the patient to approximate the physical appearance of the genotypically-other gender more closely in persons diagnosed with gender dysphoria.

Primary Sex Characteristics refer to the genetically determined sex characteristics related to reproduction. The primary sex characteristics are the genital organs and their related hormones.

Secondary Sex Characteristics refer to various genetically transmitted physical or behavioral characteristics that appear in humans at puberty and differentiate between the sexes without having a direct reproductive function.

Chest surgery-Surgical procedures to remove the breasts (mastectomy) to achieve masculinization of the chest in a FTM person and feminizing chest reconstruction (such as augmentation mammoplasty) in a MTF person.

Genital Surgery is performed for the purpose of altering the anatomy to approximate the physical appearance of the genetically other gender in persons diagnosed with gender dysphoria.

Coverage policy

Coverage for gender-affirming surgery is considered appropriate when a person has been diagnosed as having gender dysphoria and meets the clinical criteria and guidelines established by national and international experts such as the World Professional Association for Transgender Health (WPATH)

Those criteria include, but are not limited to the following:

- Persistent and well documented diagnosis of gender dysphoria
- Appropriate use of hormone therapy
- Documentation supporting that the person has lived in the gender role that is congruent with their gender identity for at least 12 continuous months
- Well controlled mental and medical health concerns
- Written referrals from clinicians familiar with the person and qualified in the behavioral aspects of gender dysphoria. A referral letter from a mental health provider must include a recent diagnostic assessment that confirms a diagnosis of gender dysphoria.

Breast and genital surgical procedures are considered irreversible. Pre-surgical medical care, hormone therapy, mental health services and living in the gender role are components that help to ensure that the person has sufficient time to absorb information fully before providing informed consent for these surgeries.

Covered procedures include:

Male to Female procedures

- Breast augmentation
- Clitoroplasty - creation of clitoris
- Electrolysis or laser hair removal to treat tissue donor sites for planned genital surgery
- Labiaplasty - creation of labia
- Orchiectomy - removal of testicles
- Penectomy - removal of penis
- Prostatectomy -removal of prostate
- Urethroplasty - creation of urethra
- Vaginoplasty - creation of vagina

Female to Male procedures

- Breast reconstruction (e.g., mastectomy or reduction mammoplasty) -removal or reduction of breast
- Electrolysis or laser hair removal to treat tissue donor sites for planned genital surgery
- Hysterectomy - removal of uterus
- Metoidioplasty - creation of micro-penis, using clitoris
- Phalloplasty - creation of penis, with or without urethra
- Salpingo-oophorectomy - removal of fallopian tubes and ovaries
- Scrotoplasty - creation of scrotum
- Testicular prostheses - implantation of artificial testes
- Urethroplasty - creation of urethra within the penis
- Vaginectomy - removal of vagina
- Vulvectomy - removal of vulva

Other covered services

- Voice therapy
- Voice modification surgery
- Electrolysis or laser hair removal from face, body and genital areas for gender affirmation

- **Services that are not covered**
  - Phalloplasty for persons under age 18.
  - ***Revision of a previous gender affirming surgery because of dissatisfaction with appearance is considered COSMETIC and not covered.***
  - Surgeries done to enhance physical appearance that are not required for the treatment of gender dysphoria are considered cosmetic

Not all services related to gender confirmation may be covered. Services that are considered cosmetic and not covered include, but are not limited to:

- Abdominoplasty
- Calf implants
- Cheek or malar implants
- Collagen injections
- Face or forehead lift
- Facial bone reconstruction
- Gluteal augmentation
- Hair transplantation
- Laryngoplasty
- Lip reduction or enhancement
- Lipofilling or collagen injections
- Liposuction
- Mastopexy
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty; nose implants
- Skin resurfacing (dermabrasion, chemical peels)
- Trachea shave or thyroid cartilage reduction (chondroplasty)

Prior Authorization
Refer to Prior Authorization List. Some cosmetic procedures require prior authorization

Related policies and documentation	
References to other policies or documentation that may be relevant to this policy	
Policy Number	**Policy Description**
CP-IFP22-027A	Cosmetic Services

References and source documents
Links to the UCare contracts, Center for Medicare, and Medicaid Services (CMS), MHCP, Minnesota statute and other relevant documents used to create this policy
Individual & Family Plans Member Contract
Individual & Family Plans Formulary
(2022) *Standards of care for the health of transsexual, transgender, and gender-nonconforming people*. World Professional Association for Transgender Health (WPATH) (8th version)
World Professional Association for Transgender Health (WPATH) (8th version) Summary
Physician and Professional Services-Gender Conforming Surgery. Minnesota Health Care Programs (MHCP) manual.
Diagnostic and Statistical Manual of Mental Disorders, (DSM-5-TR) of the American Psychiatric Association. American Psychiatric Association, DSM-5 Fact Sheets, Updated Disorders: Gender Dysphoria Archived 2016-12-29 (Washington, D.C.: American Psychiatric Association, 2013):

Coverage policy development and revision history		
Version	**Date**	**Note (s)**
V1	Jan 01, 2023	New policy
V2	Oct 23, 2023	References reviewed and added, aligned with DHS changes to include: changed hormone therapy to appropriate use of hormone therapy from 12 months of hormone therapy, removed age restriction of 18 years and older, voice therapy, voice modification surgery, electrolysis . . . moved to covered services, blepharoplasty removed from list of cosmetic procedures.