ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-063
Policy Name	Gender Affirmation Surgery and Services
Department Name	Health Care Services-Utilization Management
Policy Owner	Medical Director of Utilization Management
Line(s) of Business	Medi-Cal and Group Care
Effective Date	11/21/2013
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~8/18/2023~~1/26/2024
Compliance Committee Approval Date	TBD~~10/19/2023~~

POLICY STATEMENT

Alameda Alliance for Health (the "Alliance") covers gender affirming medically necessary care for transgender and gender diverse members~~.~~, consistent with the ~~State Medi-Cal benefit **APL 20-018,** and following the~~ World Professional Association of Transgender Health (WPATH) Standard of Care for Transgender and Gender Nonconforming People for Group Care and Medi-Cal. Gender affirming medically necessary care for Medi-Cal members is consistent with DHCS **APL 20-018**.

1. The Alliance provides medically necessary covered services to all Medi-Cal beneficiaries and Group Care enrollees, including transgender diverse (TGD) beneficiaries Gender diverse people includes but is not exhaustive to include non-binary, eunuch, and intersex individuals.
2. Medically necessary covered services are those services:
   a. Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
   b. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**
   c. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**

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d. "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

   i. In accordance with the current generally accepted standards of mental health and substance use disorder care.

   ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.

   iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provide **(Health and Safety Code section 1374.72 (3) (A)).**

3. The Alliance considers the following treatment medically necessary for all Members with gender dysphoria/gender incongruence:
   a. Mental health services, including psychotherapy;
   b. Gender affirmation (GA) feminizing/masculinizing hormone therapy and/or puberty blocker hormone therapy with clinical monitoring for efficacy and adverse events;
   c. GA surgery that is not strictly cosmetic in nature but addresses gender dysphoria/incongruence and/ or reconstructive services.
4. The Alliance must provide medically necessary reconstructive surgery to all Medi-Cal beneficiaries, including TGD beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible" **(Health and Safety Code § 1367.63~~m~~ (c) (1) (A) (B)).**
5. In analyzing GA medical and surgical service requests, the Alliance must analyze GA requests under both the applicable medical necessity standard for services to treat gender dysphoria/incongruence and under the statutory criteria for reconstructive surgery. A finding of either "medically necessary to treat gender dysphoria" or "meets the statutory criteria of reconstructive surgery" serves as a separate basis for approving the request.
6. If the Alliance determines that the service is medically necessary to treat the member's gender dysphoria/incongruence, the Alliance must approve the requested service. If the Alliance determines the service is not medically necessary to treat gender dysphoria/incongruence (or if there is insufficient information to establish medical necessity), the Alliance must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.
7. The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member's primary care provider ("PCP"), licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.
8. The Alliance will cover medically necessary medications to treat gender dysphoria/incongruence,~~,~~ mental health or substance use disorders.

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9. The Alliance is required to treat beneficiaries consistent with their gender identity **(Title 42 United States Code §18116; ~~45 Code of Federal Regulations (CFR) §§92.206, 92.207;~~ see also 45 CFR § 156.125).**
10. Federal regulations prohibit the Alliance from denying or limiting coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a TGD beneficiary based on the fact that a beneficiary's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available **(45 CFR §§92.206, 92.207 (b) (3)).**
11. DHCS indicates that Federal regulations further prohibits the Alliance from categorically excluding or limiting coverage for health care services related to gender transition **(~~45 CFR §92.207 (b) (4)~~DHCS APL 20-018).**
12. The Insurance Gender Nondiscrimination Act ("IGNA") prohibits the Alliance from discriminating against individuals based on gender, including gender identity or gender expression **(Health and Safety Code section § 1365.5).** The IGNA requires that the Alliance provide transgender beneficiaries with the same level of health care benefits available to non-transgender beneficiaries.
13. The Alliance may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determination, and/or apply appropriate utilization management criteria that are non-discriminatory. The Alliance may not categorically exclude health care services related to gender transition on the basis that it excludes those services for all members.
14. The Alliance must not categorically limit a service or the frequency of services available to a TGD member. For example, classifying certain services, such as facial feminization surgery as always "cosmetic" or "not medically necessary for any Medi-Cal member" is an impermissible "categorical exclusion" of the service. The Alliance must consider each requested service on a case-by-case basis and determine whether the requested service is either "medically necessary to treat the member's gender dysphoria" or meets the statutory definition of "reconstructive surgery."
15. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).
16. Medi-Cal is 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" **(Health and Safety Code § 1367.63(d))** or self-esteem. However, if the service request is reconstructive in nature to improve function, and/ or for the alleviation or treatment of gender dysphoria/incongruence then it would be medically necessary.

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PROCEDURE

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

- Behavioral health services;
- Psychotherapy;

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- GA feminizing/ masculinizing hormone ~~therapy~~ and/or puberty blocker hormone therapy with clinical monitoring for efficacy and adverse events;
- Surgical and GA procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender, which is not strictly cosmetic in nature. Sex reassignment surgery (also known as GA surgery), is a treatment option for TGD beneficiaries.

People with gender dysphoria/ incongruence often report a feeling of being born into the wrong sex. Sex reassignment is not a single surgical procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes.

Before undertaking sex reassignment surgery, important medical and mental health assessments should be undertaken to confirm that surgery is the most appropriate treatment choice for the individual.

Clinical guidance for the medical treatment of gender dysphoria is provided by the World Professional Association for Transgender Health (WPATH) ~~2011~~, under the current~~.~~ Standards of Care ~~(SOC)~~ for the Health of Transsexual, Transgender, and Gender Nonconforming People ~~[7th Version]. .~~ ~~https://www.wpath.org/publications/soc~~ The current WPATH Standards of Care~~OC~~ falls under the UM 001 Hierarchy for Regulatory and Contractual Requirements for national specialty guidelines. Clinical guidance for the treatment of Substance Abuse Disorder is provided by American Society of Addiction Medicine, ASAM Criteria, ~~4~~3~~th~~rd edition (202~~1~~3). Clinical guidance for mental health disorders (age 18 or older) is provided by the American Association of Community Psychiatrist, Level of Care Utilization Systems (LOCUS), Version 20. Clinical guidance for the treatment of mental health disorders (age 6-17 years) is provided by the American Association of Community Psychiatrist, Child, and Adolescent Level of Care Utilization System (CALOCUS), Version 20; or the American Academy ~~of~~ of Child and Adolescent Psychiatry, the Child and Adolescent Level of Care/Service Intensity Instrument (CALOCUS-CASII). Edition 1.2 (2020)~~Child and Adolescent Psychiatry, Child, and Adolescent Service Intensity Instrument (CASII) 2019~~. Clinical guidance for the treatment of mental health disorders (ages 0-5 years) is provided by the American Academy of Child and Adolescent Psychiatry, Early Childhood Service Intensity Instrument (ESCII).

The medical appropriateness of surgical services requested by a TGD beneficiary must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary's primary care provider or specialist; often it is a multidisciplinary team involved their care**.** The medical necessity and determination of a surgical procedure GA related or as reconstructive will be made by the Managed Care Plan.

I. Assess, Diagnose, and Discuss Treatment Options for Mental Health or Medical Conditions

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Clients presenting with gender dysphoria/incongruence may have underlying mental health or medical conditions. This could include unique anatomical, social, psychosocial, and medical comorbidity considerations. Multidisciplinary teams including a mental health professional, GA specialist and/ or surgeon, other specialists, and PCP are often involved. Adolescents uniquely will need a biopsychosocial assessment before proceeding with GA medical or surgical interventions.

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~~**II. Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):**~~

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~~a. *Fully reversible interventions.* These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.~~

~~b. *Partially reversible interventions.* These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).~~

~~c. *Irreversible interventions.* These are typically surgical procedures.~~

Although not an explicit criterion, a staged process that is defined by a surgeon in coordination with the member, is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions. New assessments and letters for each GA procedure are not required; multi-staged procedures do not require new mental health reapprovals. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

~~**Irreversible Interventions**~~

~~Genital surgery should not be carried out until (i) gender dysphoria/incongruence is marked and sustained, (ii) meet diagnostic criteria, (iii) demonstrate emotional and cognitive maturity to provide informed consent (iv) mental health concerns are addressed and potential interference in their treatments; (v) informed discussion about reproductive effects from treatment; (vi) TGD member has reached Tanner stage 2. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.~~

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The intent of this suggested sequence is to give adolescents and adults sufficient opportunity to experience and socially adjust to the new gender role and achieve the desire optimal hormonal result. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression. It is recommended that health care professionals maintain an

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ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment and hormonal treatment until the transition is made to adult care.

~~III.~~II. Written Assessment to Support Gender Affirming Hormone Therapy or Surgical Procedures. (1 Letter/ Documentation)

One written documentation or letter is required from a qualified health professional who has competency in the assessment of TGD people, to recommend for medical or surgical treatment. Thi~~, thi~~s can be a single letter that summarizes the single opinion for medically necessary ~~TG~~ GA treatment. ~~This health care professional must have competency in the assessment of TGD people.~~

Adolescents will additionally need a comprehensive biopsychosocial assessment: including input from relevant mental health and medical professionals. Involvement of parents(s)/ guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible[1]. A single letter from the adolescent's multidisciplinary team is needed and this letter can summarize the assessment and opinion from the team or single provider involving both medical and mental health professionals (American Psychological Association, 2015; Hembree et al., 2017; Telfer ~~et al.~~et al., 2018). It is recommended but not required for the health care professional to liaise with multidisciplinary trans health professionals who are from different disciplines within the field of trans health.

Although not explicit criteria, the recommended content of the letter for GA hormone therapy or surgical intervention from a health care professional who has competency in the assessment of TGD people is as follows:

- The client's general identifying characteristics
- An explanation that the criteria for GA hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy
- Results of the members' psychosocial assessment (if applicable), including review of any medical or mental health diagnoses that may negatively interfere with the proposed GA treatments; risks and benefits were discussed before a treatment decision is made
- The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy, or counseling to date
- A statement that informed consent has been obtained from the member or parent/ guardian.

[1] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

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- A statement that the referring health professional is available for coordination of care before and after interventions are initiated and for the duration of hormonal therapy

An assessment and psychosocial interventions for ~~children and~~ adolescents are often provided within a multidisciplinary gender identity specialty service. For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the member's chart as a comprehensive assessment. Although not explicit criteria, if such a multidisciplinary service is not available, then the health plan recommends that a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist[2] for the purpose of assessment, education, and involvement in any GA decisions.

~~**Although not explicit criteria, the recommended content of the referral letter for GA surgery who has competency in the assessment of TGD people is as follows:**~~

1. ~~The client's general identifying characteristics~~
1. ~~An explanation that the medical necessity criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery~~
2. ~~Results of the members' psychosocial assessment (if applicable), including review of any medical or mental health diagnoses that may negatively interfere with the proposed GA treatments; risks and benefits were discussed before a treatment decision is made~~
3. ~~The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy or counseling to date~~
4. ~~A statement that informed consent has been obtained from the member~~
5. ~~A statement that the referring health professional is available for coordination of care before and after interventions are initiated and for the duration of hormonal therapy~~

If the GA surgeries are staged a single letter that outlines multiple staged interventions is also acceptable. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

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~~IV.~~III. Eligibility Criteria for Gender-Affirming Hormone Therapy or Puberty Blocker Hormones for ~~Children~~Adolescents (<~~under age~~ 18 Years Old)

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[2] If puberty blockers or gender-affirming hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone prescribing provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

Feminizing/ masculinizing hormone therapy (or puberty blockers) may lead to irreversible physical changes. ~~For the Alliance to approve hormone therapy members under 18 must meet ALL~~ All of the criteria below must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained.
2. Meets the criteria for diagnostic criteria for gender dysphoria/ gender incongruence;
3. Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives[3].
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. The adolescent has been informed of the reproductive effects, including potential loss of fertility and options for fertility preservation, and the context of the adolescent's stage of puberty development;
6. The adolescent has reached Tanner stage 2 ~~of puberty for pubertal suppression or hormone treatments.~~

~~V.~~IV. Eligibility Criteria Gender Affirming Hormone Therapy for Adults ~~over~~ (≥ -18 Y~~y~~ears O~~o~~ld)~~.~~

~~Two goals justify intervention with gender-affirming hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.~~

All~~LL~~ of the following criteria must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets diagnostic criteria for gender dysphoria/ gender incongruence prior to initiating GA hormone treatment;

~~3. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;~~

~~4.~~3. ~~The member has signed informed consent, documenting capacity to make an informed decision~~Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;

[3] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

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4. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;
5. Mental health and physical conditions that could negatively impact the outcome of the treatment have been assessed, with risks and benefits discussed;
6. Understands the effects of GA hormone treatment on reproduction and they have explored reproductive options.

V. ~~VI.~~ Gender Affirmation Surgery

A. Eligibility Criteria for Gender Affirmation Surgery in Adolescents (< 18 Years Old)

For adolescents undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 8):

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
3. Demonstrates the emotional and cognitive maturity required to provider informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives;
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. Informed of the reproductive effects, including potential loss of fertility and the available options to preserve fertility;
6. At least 12 months of GA hormone therapy or longer, if required, to achieve the desired surgical result for GA procedures, including breast growth and skin expansion prior to breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty (with or without scrotoplasty), and facial surgery as part of GA treatment unless hormone therapy is either not desired or is medically contraindicated.

~~Eligibility Criteria for Gender Affirmation Surgery~~

B. ~~C.~~ Gender Affirming Surgery in Adults (≥ 18 Years Old)

For ~~individuals~~ adults undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 7~~8~~):

~~1. Member is 18 years old or older;~~
1. Gender dysphoria/ gender incongruence is marked and persistent;
2. Meets diagnostic criteria for gender incongruence prior to GA surgery interventions;

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3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
3. The individual has capacity to make informed decisions and consent for the specific surgical intervention;
4. Understands the effect of gender-affirmingGA surgical intervention on reproduction and they have explored reproductive options;
5. Other possible causes of apparent gender dysphoria/ incongruence have been identified and excluded;
6. Mental health and physical conditions that could negatively impact the outcome of gender-affirmingGA surgical intervention have been assessed, and risks and benefits have been discussed;.
7. Both mental health and medical professionals have been involved in the decision-making process. Stable on their GA hormonal treatment regimen (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).

If requesting a GA gonadectomy surgery (i.e.i.e., Hysterectomy and/or salpingo-oophorectomy, or orchiectomy) the following additional criteria is requiredalthough not an explicit criterion, it is recommended that–: (1-8, 9):

- 9. The member has tolerated a minimum of 6 months or longer of hormonal therapy (or longer period if required to achieve the desired surgical result) as appropriate to achieve the desired surgical result, unless hormones are not clinically indicated, not desired, orit is medically contraindicated or not desired[4].

If requesting genital procedures (i.e. metoidioplasty (including placement of testicular prosthesis), phalloplasty (including placement of testicular/ penile prosthetics), vulvectomy, vulvoplasty, vaginoplasty, penectomy, perinoplasty, clitoroplasty, colpoclesis, labiaplasty, vaginectomy, scrotectomy, scrotoplasty, slit meatoplasty, urethroplasty, or placement of testicular prostheses) the following additional criteria is required: (1-8, 9):

10. The member has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required[5]) to achieve the desired surgical result, unless hormone therapy is either medically contraindicated or not desired.

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

[4] The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.
[5] Longer hormone therapy may be required for sufficient clitoral virilization prior to metoidioplasty/ phalloplasty.

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~~Although not an explicit criterion, it is recommended that:.~~

~~a) There is a multidisciplinary team of professionals in the field of transgender health when TGD people request individually customized (previously termed "non-standard") surgeries as part of a gender-affirming surgical intervention.~~

~~a) If requesting a breast augmentation or mastectomy, it is recommended that the surgeon assess for risk factors associated with breast cancer prior to breast augmentation or mastectomy.~~

~~b) Surgeons caring for transgender men and gender diverse people who have undergone metoidioplasty /phalloplasty encourage lifelong urological follow-up.~~

~~c) Surgeons caring for transgender women and gender diverse people who have undergone vaginoplasty encourage follow-up with their primary surgeon, primary care physician, or gynecologist.~~

D. FACIAL FEMINIZATION SURGERY & VOICE AND COMMUNICATION THERAPY

Facial feminization surgery (including chondrolaryngoplasty/ vocal cord surgery) is considered a medically necessary to correct a significant physical functional impairment related to treating gender dysphoria/ gender incongruence, and/ or improve the physical functional impairment respectively. Examples include, but are not limited to, reconstructive procedures which correct or improve a significant functional impairment of speech, such as voice feminization/ modification surgery, nutrition, control of secretions, protection of the airway, or corneal protection. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's request for facial reconstruction surgery. **All basic GA surgery criteria must be met (1-7~~8~~).**

Facial feminization surgery is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or to treat gender dysphoria/ gender incongruence. Facial feminization surgery is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance (cosmetic in nature).

Note: The initial restoration may be completed in stages. New mental health assessments and letters are not required for each staged GA procedure; they do not require reapproval.

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Voice feminization surgery to obtain a ~~deeper~~ higher voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective. All basic GA surgery criteria must be met (1-7~~8~~).

Although not explicit criterion, it is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication.

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence, or physical functional impairment/ physical reconstruction.

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Voice and communication therapy may be medically necessary to treat gender dysphoria/incongruence, or to help individuals develop verbal (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication skills (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity through individual and/or group sessions, and to prevent the possibility of vocal misuse and long-term vocal damage. Therapy is conducted with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/ speech-language pathologists. These pre and post interventions may be needed after voice surgery, or testosterone therapy.

For the following GA reconstructive procedures: ~~**(#1-8)**~~

All basic GA surgery criteria must be met (1-7). Additionally, they are medically necessary if they treat gender dysphoria/incongruence, or to treat physical functional impairment/ physical reconstruction. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested facial reconstruction surgery.

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1. **Blepharoplasty, Blepharoptosis Repair, and Brow Lift**
   Upper eyelid blepharoplasty or blepharoptosis repair is considered medically necessary for ANY of the following conditions.

2. To treat gender dysphoria/gender incongruence;

a. Difficulty tolerating a prosthesis in an ophthalmic socket; or
b. Repair of a functional defect caused by trauma, tumor, or surgery; or
c. Periorbital sequelae of thyroid disease; or
d. Nerve palsy

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Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

3. Blepharoplasty

Unilateral or bilateral upper eyelid blepharoplasty is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a, or b, and c-d):

a. To treat gender dysphoria/gender incongruence; or

b. Documented complaints of interference with vision or visual field-related activities causing significant functional impact such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue; and

d. Prior to manual elevation of redundant upper eyelid skin (taping), the superior visual field is:

1) less than or equal to 20 degrees, or there is a 30 percent loss of upper field of vision compared to normal; and

2. Manual elevation (taping) of the redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

4. Eye Lid Surgery (Blepharoptosis Repair)

Blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a, or b, c through e):

a. To treat gender dysphoria/gender incongruence; or

b. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; and

c. Photographs taken with the camera at eye level and the individual looking straight ahead, document the abnormal lid position (photos should be submitted for review); and

d. Prior to manual elevation of the upper eyelid and redundant upper eyelid skin (taping), the superior visual field is a) less than or equal to 20 degrees or b) there is a 30 percent loss of upper field of vision compared to normal, or c) the margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm; and

e. Manual elevation (taping) of the upper eyelid and redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

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5. **Brow Lift**

Brow lift (that is, repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when the following criteria are met (a~~,~~ or ~~b, and~~b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. Brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. Photographs show the eyebrow below the supraorbital rim.

Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered not medically necessary when the criteria noted above are not met.

- Blepharoplasty, blepharoptosis repair, or brow lift is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance.

- Lower lid blepharoplasty is considered not medically necessary.

- Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature, or there is a medical need to treat gender dysphoria/gender incongruence**.**

6. **Otoplasty**

Otoplasty is considered medically necessary when performed to surgically correct a physical structure or absence of a physical structure that is causing hearing loss, or intended to facilitate the use of a hearing aid or device when both of the following criteria are met (a~~,~~ or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. The procedure is reasonably expected to improve the physical functional impairment; and

c. An audiogram documents a loss of at least 15 decibels in the affected ear(s).

Otoplasty is considered reconstructive when intended to restore a significantly abnormal external ear or auditory canal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered reconstructive when intended to restore the absence of the external ear due to accidental injury, disease, trauma, or the treatment of a

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disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence.

Otoplasty is considered not medically necessary when performed strictly to alter or reshape normal structures of the body to improve appearance. Examples include, but are not limited to, repair of ear lobes with clefts or other consequences of ear piercing, or protruding ears.

Otoplasty is considered not medically necessary when the gender dysphoria/gender incongruence, or medically necessary reconstructive criteria in this section are not met.

7. Nasal Procedures - Rhinoplasty or rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)

Rhinoplasty is considered medically necessary when both of the following criteria are met (a, or b, and c):

a. To treat gender dysphoria/gender incongruence; or
b. The medical record documentation includes evidence of the failure of conservative medical therapy for severe airway obstruction from deformities due to disease, structural abnormality, or previous therapeutic process that will not respond to septoplasty alone; and
c. The procedure can be reasonably expected to improve the physical functional impairment;

- Rhinoseptoplasty is considered medically necessary when gender dysphoria/gender incongruence, or the criteria above for rhinoplasty are met and medically necessary criteria in MCG guideline ACG: A-0182 Septoplasty are also met.

- Rhinoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal fracture.

- Rhinoseptoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal and septal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal and septal fracture.

- Rhinoplasty or rhinoseptoplasty to modify the shape or size of the nose is considered not medically necessary when the gender dysphoria/gender

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incongruence medical necessity, or reconstructive criteria in this section are not met.

8. Face lift (Rhytidectomy)
Rhytidectomy is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/gender incongruence. Examples include, but are not limited to, significant burns or other significant major facial trauma.

Rhytidectomy is considered not medically necessary when the gender dysphoria/gender incongruence, or reconstructive criteria in this section are not met, including but not limited to, removal of wrinkles, excess skin, or to tighten facial muscles.

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9. Hair Removal
Hair removal consultation is covered for the genital area when authorization is in place for gender GA surgery, or it is necessary intervention in preparation for surgery. Consultation is needed for the removal of body hair for feminization from the face, chest, back, abdomen, genitalia, arms, and legs if there is persistent gender dysphoria/ gender incongruence, or there is significant disruption of professional and/ or social life because of hirsutism with some medical evaluation outlining the psychological distress related to unwanted hair and justification of medical necessity. Other medical reasons may include if a hair loss response has not been noticed after one year of hormone treatment. Hair reduction procedures include:

(a) Laser Epilation/Hair Removal require:
- (i) to be provided by a physician, PA, NP, or RN (requires physician supervision);
- (ii) Informed consent;
- (iii) Documentation justifying laser hair removal for specific body areas

(b) Electrolysis Hair Removal require:
- (i) Documentation of consultation by a physician, PA, NP, or RN (requires physician supervision);
- (ii) Informed consent;
- (iii) Documentation justifying laser hair removal for specific body areas
- (iv) Justification as to why a trial of laser hair removal should not pre~~e~~ceed electrolysis;
- (v) Electrolysis will be provided by a licensed electrologist.

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E. Additional Procedures for Body Feminization or Body Masculinization
The following procedures are medically necessary when they are requested for the treatment of gender dysphoria/ gender incongruence, or reconstructive surgery (to

correct or repair abnormal structures of the body to create a normal appearance for the target gender to the extent possible). All basic GA surgery criteria must also be met (1-7~~8~~). The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested surgical or reconstructive procedure.

- Abdominoplasty
- Body contouring (liposuction, lipofilling, Implants, monsplasty/ mons reduction)
-
- Cheek surgery
- Chin Shaping
- Facial bone reconstruction
- Gluteal augmentation
- Hair removal/ hairplasty, when the criteria above have not been met.
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Suction-assisted Lipoplasty/ trunk contouring
- Otoplasty
- Tattoo (i.e., nipple/ areola~~e~~)
-
- Penile prosthesis in the setting of proposed or completed phalloplasty
- Thyroid cartilage reduction/Tracheal shave feminization (larygeochondroplasty)
- Voice Modification Surgery

F. Revisions of Gender-Affirming Surgery (1 Letter Assessment)
The Alliance authorizes requests for surgical revision on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity to treat gender dysphoria/ gender incongruence and/or reconstructive surgery. Clinical documentation must support medical necessity to treat gender dysphoria/ gender incongruence or reconstructive surgery. Surgical revision requests require all of the following:

a. Medical and/or functional complications of prior ~~gender-affirming~~GA procedure;
b. Measurements and/or photographs of deformity/asymmetry (if applicable);
c. Members who regret their ~~gender-related~~GA surgical intervention are to be managed by an expert multidisciplinary team.
d. Endorsement of medical necessity or reconstructive purpose from the performing surgeon.

The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

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VI. Standard Fertility Preservation Services
For coverage options please refer to the UM-057 policy under the Standard Fertility Preservation Services section.

DEFINITIONS / ACRONYMS

DISORDERS OF SEX DEVELOPMENT (DSD): Refers to a group of medical conditions (i.e., Klinefelter Syndrome, Turner Syndrome, Androgen Insensitivity Syndrome, Congenital Adrenogenital Disorders, Congenital Adrenal Hyperplasia) in which anatomical, chromosomal, or gonadal sex varies in some way from what would be typically considered male or female. The *DSM*–5 criteria for gender dysphoria were revised to allow the diagnosis to be given to individuals with DSD.

EMANCIPATED MINOR: A minor (person who is not an adult) who is self-supporting and independent of parental control, usually as a result of court order (Cal. Fam. Code § 7122). Some examples are persons under the age of 18 who are married, or a minor who is on active duty with the armed forces (Cal. Fam. Code § 7002).

EUNUCH: People who are assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning. This also includes those whose testicles have been surgically removed or rendered nonfunctional by chemical or physical means and who identify as eunuch. This doesn't include men who have been treated for advanced prostate cancer and reject the designation of eunuch.

FEMALE TO MALE (FtM)
A person assigned female sex at birth and later adopts the identity, appearance, and gender role of a male, especially after gender confirmation surgery.

GENDER-AFFIRMING HEALTH CARE: means medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, the following:

- Interventions to suppress the development of endogenous secondary sex characteristics.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and

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- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.

GENDER DYSPHORIA:
DSM-5 defines gender dysphoria as the distress that may accompany incongruence between one's experienced or expressed gender and one's assigned gender at birth. Gender dysphoria is treated as a developmental abnormality for purposes of the reconstructive statute and normal appearance is to be determined by referencing the gender with which the member identifies **(Health and Safety Code 1367.63(c)(1)(B)).** Gender non-conformity is not in itself a mental disorder.

GENDER DYSPHORIA/ INCONGREUENCEIN IN CHILDREN[6]
A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion 1):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play of fantasy play.
- A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

GENDER DYSPHORIA/ GENDER INCONGREUENCE IN ADOLESCENTS AND ADULTS[7]

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).

[6] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.
[7] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

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2. 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 (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. 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).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if there is a DSD that is also relevant. Coding note: Code the disorder of sex development as well as gender dysphoria/ gender incongruence.

GENDER NON-BINARY

Non-binary or gender queer is a spectrum of gender identities that are not exclusively masculine or feminine—identities that are outside the gender binary. Non-binary identities can fall under the transgender umbrella, since many non-binary people identify with a gender that is different from their assigned sex. The term nonbinary includes people whose genders ~~are~~ comprise~~d of~~ more than one gender identity simultaneously or at different times (e.g., bigender), who do not have a gender identity or have a neutral gender identity (e.g., agender or neutrois), have gender identities that encompass or blend elements of other genders (e.g., polygender, demiboy, demigirl), and/or who have a gender that changes over time (e.g., genderfluid)

IATROGENIC INFERTILTY

Infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

MALE TO FEMALE (MtF)

A person assigned male at birth and later adopts the identity, appearance, and gender role of a female, especially after gender confirmation surgery.

MEDICAL NECESSITY

- Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
- For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant

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illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**
- "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
    - In accordance with the current generally accepted standards of mental health and substance use disorder care.
    - Clinically appropriate in terms of type, frequency, extent, site, and duration.
    - Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provide **(Health and Safety Code section 1374.72 (3) (A)).**

~~**Minor Services:** California state law permits minors of any age to consent to/receive certain services. Please refer to Sections 5 "California Minor Consent Services.~~

POST TRANSITION

The individual has transitioned to full-time living in the desired identity-congruent gender role (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender reassignment surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female). This ensures treatment access for individuals who continue to undergo hormone therapy, related surgery, or psychotherapy or counseling to support their gender transition.

QUALIFIED MENTAL HEALTH PROFESSIONAL

The mental health professional must have appropriate training:

- Have a Master's degree or, equivalent or higher, in a clinical mental science field (such as social work, psychology or marriage and family therapist) and licensed by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution
- Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.

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- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

QUALIFIED MEDICAL PROFESSIONAL

- The medical professional must have appropriate training and licensed to by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

RECONSTRUCTIVE SURGERY

In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/incongruence. Reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible. **(Health and Safety Code 1367.63).**

TRANSGENDER AND GENDER DIVERSE (TGD) PEOPLE: A broad and comprehensive as possible phrase in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. May include non-binary, eunuchs, and other non-confirming gender identities.

STANDARD FERTILITY PRESERVATION SERVICES

Procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

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CMP-015 Minor Consent to Medical Care

CMP-008 Members Rights to Release PHI

G&A-008 Adverse Benefit Determination Appeals Process

RX-002 PA Review Process

RX-003 Exception Review Process

RX-004 Formulary Management

UM-001 Utilization Management Program

UM-012 Care Coordination-Behavioral Health

UM-062 Behavioral Health Treatment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2013, 11/15/2018, 10/29/2020, 12/14/2020, 1/21/21, 05/20/2021, 08/24/2021, 4/27/2022, 6/28/22, 9/27/2022, 02/21/2023, 6/20/2023, 10/19/2023

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DHCS: All Plan Letter [APL] 20-018: Ensuring Access to Transgender Services

DHCS Provider Manual, Family Planning, August 2020~~, page 1.~~.

DMHC All Plan Letter [APL] 20-002: Implementation of SB 855, MH.SUD Coverage

State Laws:
Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020). Section 1374.551. (a)

Insurance Gender Nondiscrimination Act - Health & Safety Code § 1365.5

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Civil Rights Protections - Govt. Code § 11135
Department of Fair Employment and Housing Definitions -Govt. Code § 12926 (r)(2)
DMHC Director's Letter 12-K Gender Nondiscrimination Requirements

Federal Laws:
Nondiscrimination in Health Programs or Activities Receiving FFA or Administered by DHHS Under Title I of the ACA - 45 CFR §§ 92.206, 92.207
Section 1557 of the ACA - 42 USC § 18116

National Oranizations:
WPATH [World Professional Association for Transgender Health], the current ~~STANDARDS~~ Standards of~~OF~~ Care~~ARE~~ for the Health of Transgender and Gender Diverse People~~, Version 7, 2011.~~.

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MONITORING

Annual audit based on CPT codes submitted.

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