Utilization *ALERT*

- Before using this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- This medical coverage policy applies to District of Columbia situs members only.
- For Maryland or Virginia Commercial, Medicare, and Medicaid members, please refer to the applicable benefit plan or state guidelines.
- For Federal Employees, breast augmentation is not a covered benefit per Office of Personnel Management (OPM). Please refer to federal benefit requirements for details
- Please refer to CMS guidelines: National Coverage Determination (NCD) or Local Coverage Determination (LCD) for Medicare members. This MCP applies if no CMS criteria are available.

I. Internal & Outside Referral Guidelines

A. Kaiser Foundation Health Plan (KFHP) provides Gender Confirmation Surgery (GCS) for the treatment of patients with gender incongruence and meet the medical criteria below.

B. KFHP commits to following the most recent version of The World Professional Association for Transgender Health. Currently, we are following the World Professional Association for Transgender Health (WPATH) standards of care, 8th Version, for covered services. standards of care for covered services.

C. Both surgical and non-surgical services (labs, hormonal therapy, and mental health services) are covered for transition-related treatment under base benefits.

D. All referrals require review by the Gender Pathways Medical Lead.

II. Covered Sexual Reassignment Surgery Procedures

A. **Male-to-Female (MtF):** Clitoroplasty, Intersex Surgery, Labiaplasty, Orchiectomy, Penectomy, Vaginoplasty, Tracheal Shave, Facial Feminization.

B. **Female-to-Male (FtM):** Glansplasty, Hysterectomy, Intersex Surgery, Mastectomy with Chest Reconstruction, Metoidioplasty, Mons Resection, Penile Prothesis, Phalloplasty, Salpingo-Oophorectomy, Scrotoplasty, Testicular Prosthesis, Urethroplasty, Vaginectomy., Facial Masculinization.

III. Genital Surgery Clinical Review Criteria

Members must meet **all** of the following criteria for genital surgery coverage:

A. Member is at least 18 years old; **and** Gender Incongruence is marked and sustained such that:
   1. Member experiences discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics); **and**
   2. Other possible causes of apparent gender incongruence have been identified and excluded; **and**

B. Member has the capacity to make fully informed decisions and to consent to treatment; **and**

C. If significant medical or mental health concerns are present, they are well controlled; **and**

D. Member has completed a program of gender incongruence evaluation and treatment, as evidenced by all the following:
   1. Member has undergone or is in the process of completing 6 continuous months of hormone therapy as appropriate to the patient's gender identity (unless the patient has a medical contraindication or does not desire to take hormones); **and**
   2. Member has one evaluation letter recommending GCS from a qualified mental health professional who has independently assessed the patient. The referral should be from a person who has only had an evaluative role with the patient. The referral letter is expected to cover the following recommended content:
      a. The member's general identifying characteristics;
      b. Results of the member's psychosocial assessment, including any diagnoses;
      c. The duration of the mental health professional's relationship with the Patient, including the type of evaluation and therapy or counseling to date;
      d. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery
      e. A statement about the fact that informed consent has been obtained from the patient;
      f. A statement that the member understands the effect of gender-affirming surgical intervention on reproduction and they have explored fertility preservation options if so desired;
      g. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this; **and**
   3. Member has had a mental health evaluation and a medical evaluation, which has deemed the patient to have no medical or psychological contraindications for surgery. Additionally, the care team has reviewed the selection of surgical procedures and has deemed them medically necessary; **and**
   4. FtM members requesting metoidioplasty or phalloplasty and MtF members requesting vaginoplasty must also have undergone or be in the process of completing 12 continuous months of living in the identified gender role.

IV. Mastectomies with Chest Reconstruction Clinical Review Criteria:

FtM members are eligible for Mastectomies with Chest Reconstruction and should meet **all** the following criteria:

A. Member is at least 18 years old or 16 years and older with either parental consent or legal emancipation after ample time of living in the desired gender role. **and**

B. Member has been diagnosed with Gender Incongruence that is marked and sustained such that:
   1. Member experiences discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics); **and**
   2. Other possible causes of apparent gender incongruence have been identified and excluded; **and**

C. Member has the capacity to make fully informed decisions and to consent to treatment; **and**

D. If significant medical or mental health concerns are present, they are well controlled; **and**

E. Member has one letter of recommendation for breast/chest surgery from a qualified mental health professional who has independently assessed the patient. For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the patient's chart. The referral is expected to cover the following recommended content:
   1. The member's general identifying characteristics; and
   2. Results of the member's psychosocial assessment, including any diagnoses; and
   3. The duration of the mental health professional's relationship with the member, including the type of evaluation and therapy or counseling to date; and
   4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; and
   5. A statement about the fact that informed consent has been obtained from the patient; and
   6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this; **and**

F. Member has had a mental health evaluation and a medical evaluation, which has deemed the patient to have no medical or psychological contraindications for surgery.

V. Male to Female Chest Surgery, Breast Augmentation Clinical Review Criteria

MtF members are eligible for Breast Augmentation and should meet **all** of the following criteria**:**

A. Member is at least 18 years old except for MtF members under the age of 18; chest surgery can be carried out on adolescents 16 years or older, after ample time of living in the identified gender role and after at least one year of estrogen treatment (unless hormonal therapy is

contraindicated). Adolescent MtF patients seeking chest surgery must also have parental consent or be legally emancipated; **and**

B. Member has been diagnosed with Gender Incongruence that is marked and sustained such that:
   1. Member experiences discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics); **and**
   2. Other possible causes of apparent gender incongruence have been identified and excluded; **and**

C. Member has the capacity to make fully informed decisions and to consent to treatment; **and**

D. If significant medical or mental health concerns are present, they are well controlled; **and**

E. Member has one letter of recommendation for breast/chest surgery from a qualified mental health professional who has independently assessed the patient. For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the patient's chart. The referral is expected to cover the following recommended content:
   1. The member's general identifying characteristic;
   2. Results of the member's psychosocial assessment, including any diagnoses;
   3. The duration of the mental health professional's relationship with the member, including the type of evaluation and therapy or counseling to date;
   4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; **and**

F. Surgical breast augmentation will be evaluated for coverage after 6 months of hormonal therapy; or, If the patient is unable to take hormones due to medical contraindications patient will be assessed by plastic/reconstructive surgeon for appropriate surgical intervention.

VI. Exclusions/Limitations

A. Cosmetic surgery is deemed unrelated to gender dysphoria.

B. Tracheal Shave procedure (chondrolaryngoplasty) will be limited to members 18 years and older; **and**

C. Gender affirming facial procedures require at least 12 months of Hormone Replacement Treatment (HRT) unless contraindicated or member declines

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Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
06/30/2015 **WITHDRAWN FROM REVIEW 5/28/2015**	07/02/2015
06/30/2015	07/02/2015
06/30/2016	06/30//2016
06/28/2017	06/28/2017
06/27/2018	06/27/2018
06/24/2019	06/24/2019
06/25/2020	06/25/2020
06/24/2021	06/24/2021
06/20/2022	06/20/2022
12/28/2022	12/28/2022
11/28/2023	11/28/2023
11/21/2024	11/21/2024

*****The Regional Utilization Management Committee received ***delegated authority*** to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee in 2011.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Whenever possible, Medical Coverage Policies are evidence-based and may also include expert opinion. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.

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