Gender Affirmation Surgery for the Treatment of Gender Dysphoria

4.238 Gender Affirmation Surgery for the Treatment of Gender Dysphoria (11/1/2019, GCR 19-021)

4.238.1 Definitions

For the purposes of this rule, the term:

(a) **"Gender Affirmation Surgery"** means the surgical procedures by which the physical appearance and function of a person's primary and/or secondary sex characteristics are modified to establish greater congruence with their gender identity.

(b) **"Gender Dysphoria"** means a clinical diagnosis as provided in the *Diagnostic and Statistical Manual of Mental Disorders (Latest Edition)* definition of Gender Dysphoria, or any successor diagnosis.

(c) **"Gender Identity"** means an individual's intrinsic sense of being a man, woman, neither, both, or an alternative gender, or characteristics intrinsically related to an individual's gender, regardless of the individual's sex assigned at birth.

(d) **"Gender Role"** means the lived role or expression characterized by a person's personality, appearance, and behavior that in a given culture and historical period is designated as masculine, feminine, or an alternative gender role.

(e) **"Qualified Mental Health Professional"** means a licensed practitioner, practicing within their scope, who possesses the following minimum credentials:
(1) A masters level degree or a more advanced degree in a clinical behavioral science field, granted by an institution accredited by the appropriate national or regional accrediting board, and
(2) Ability to recognize and diagnose co-occurring mental health concerns and to distinguish these from gender dysphoria.

4.238.2 Covered Services

Coverage is available, as specified below, for gender affirmation surgeries for the treatment of gender dysphoria. Coverage includes only the specific surgeries stated as covered below. Prior authorization is required for all gender affirmation surgeries for the treatment of gender dysphoria.

Covered surgeries are limited to the following:
(a) Orchiectomy,
(b) Penectomy,
(c) Vaginoplasty (including hair removal when required),
(d) Clitoroplasty,
(e) Labiaplasty,
(f) Hysterectomy,

(g) Salpingectomy,
(h) Oophorectomy,
(i) Salpingo-oophorectomy,
(j) Vaginectomy,
(k) Prostatectomy,
(l) Metoidioplasty,
(m) Scrotoplasty,
(n) Urethroplasty,
(o) Phalloplasty (including hair removal when required),
(p) Testicular prosthesis,
(q) Breast augmentation mammoplasty, and
(r) Mastectomy.

4.238.3 Eligibility for Care

Vermont Medicaid beneficiaries who are diagnosed with and receiving treatment for gender dysphoria, who satisfy all conditions set forth in this rule, and for whom the service(s) for which prior authorization is sought is both medically necessary and developmentally appropriate are eligible for coverage of the services governed by this rule.

4.238.4 Qualified Providers

Gender affirmation surgery is only covered when the surgeon performing the surgery is a board-certified urologist, gynecologist, or plastic or general surgeon, as appropriate to the requested service. The surgeon must have demonstrated specialized competence in genital and/or breast reconstruction. Any service covered by Medicaid under this rule must be provided by a licensed and enrolled Medicaid provider working within their scope of practice.

4.238.5 Conditions for Coverage

(a) For a beneficiary to receive coverage for gender affirmation surgery, the following conditions must be met:

(1) Written clinical evaluation that may be in the form of a letter documenting eligibility and medical necessity from qualified mental health professional(s):
  (A) For breast surgery, a written clinical evaluation must be submitted by one qualified mental health professional.
  (B) For genital surgery, two written clinical evaluations must be submitted by two separate qualified mental health professionals. The first referral should be from the individual's treating qualified mental health professional, and the second referral may be from a person who has only had an evaluative role with the individual.
  (C) A written clinical evaluation by a qualified mental health professional will include at a minimum:
    (i) A diagnosis of persistent gender dysphoria, with demonstrated participation in a treatment plan in consolidating gender identity,

(ii) Diagnosis and treatment of any co-morbid conditions,
(iii) Counseling of treatment options and implications,
(iv) Pyschotherapy, if indicated,
(v) Affirmation that the beneficiary has been assessed face-to-face by the qualified mental health professional,
(vi) Formal recommendation of readiness for surgical treatment, documented in a letter that includes:
(1) Documentation of all diagnoses,
(2) Duration of professional relationship and type of therapy,
(3) Rationale for surgery, and
(4) Follow-up treatment plan.

(2) Documentation of medical necessity from a medical provider working in conjunction with the qualified mental health professional(s).

(3) Completion of at least 12 months of living in a gender role that is congruent with their gender identity.

(4) Documentation of hormonal therapy, as appropriate to the beneficiary's gender goals, unless such therapy is medically contraindicated. Specific hormonal therapy pre-requisites are as follows:
(A) At least 12 consecutive months for metoidioplasty, phalloplasty, vaginoplasty, and breast augmentation mammoplasty.
(B) There is no hormonal therapy pre-requisite for coverage of mastectomy.

(5) Documented informed consent, including knowledge of risks, hospitalizations, post-surgical rehabilitation, and compliance of treatment. For minors under 18 years of age, documented informed consent of a parent(s), legal custodian, or guardian is also required unless the minor is emancipated by court order.

(b) Breast augmentation mammoplasty may be considered medically necessary when clinical criteria is met and when 12 months of continuous hormone therapy has not resulted in breast development that, in the opinion of the qualified mental health professional, is sufficient to treat the beneficiary's symptoms of gender dysphoria.

(c) When treatment for gender dysphoria includes a hysterectomy, coverage is contingent on meeting conditions described in HCAR 4.224.1(b).

4.238.6 Prior Authorization Requirements

Prior authorization is required for all gender affirmation surgeries for the treatment of gender dysphoria. Every request for prior authorization under this rule will be reviewed on an individual basis.

4.238.7 Non-Covered Services

(a) Non-covered services include any service that is not explicitly listed as a covered service above.

(b) Vermont Medicaid does not cover reversal of the surgeries approved under this rule. Cryopreservation, storage, or thawing of reproductive tissue is not covered.

(c) Coverage is not available for surgeries or procedures that are cosmetic, as defined in HCAR 4.104 Medicaid Non-Covered Services, i.e., that change a beneficiary's appearance but are not medically necessary to treat the patient's underlying gender dysphoria.