



IEHP UM Subcommittee Approved Authorization Guideline			
<b>Guideline</b>	Transgender Services	<b>Guideline #</b>	UM_SUR 04
		<b>Original Effective Date</b>	5/14/2014
<b>Section</b>	Surgery	<b>Revision Date</b>	11/10/2021

### COVERAGE POLICY

- A.** Requests for transgender services should be supported by evidence of either medical necessity to treat gender dysphoria or evidence supporting the statutory 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.
- B.** IEHP provides medically necessary covered services to all Members. A “medically necessary” service is defined as:
  - 1. For individuals 21 years of age or older: a service which is reasonable and necessary to protect life, prevent significant illnesses or disability or to alleviate severe pain (CA Welfare and Institutions Code Section 14059.5).
  - 2. For individuals under 21 years of age: a service that corrects or ameliorates defects and physical and mental illnesses and conditions (Title 42, United States Code Section 1396d(r)(5)).
- C.** IEHP considers the following treatment medically necessary for Members with gender dysphoria:
  - 1. Behavior health services, including psychotherapy;
  - 2. Feminizing/masculinizing hormone therapy and/or puberty suppression hormone therapy with clinical monitoring for efficacy and adverse events; and
  - 3. Gender-affirmation surgery that is not cosmetic in nature.
- D.** IEHP also provides reconstructive surgery to all Members, including transgender Members. The analysis of whether or not a surgery is considered reconstructive surgery is separate and distinct from a medical necessity determination.
  - 1. 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 (CA Health and Safety Code Section 1367.63).
  - 2. In the case of transgender Members, gender dysphoria is treated as a “developmental abnormality” (DSM-5) for purposes of the reconstructive statute and “normal” appearance is to be determined by referencing the gender with which the Member identifies (CA Health and Safety Code Section 1367.63(c)(1)(B)).
- E.** There must not be a categorical limitation of a service or frequency of services available to a transgender Member. Each requested service must be considered on a case-by-case basis.

## **Qualification Process of Gender-Affirming Treatments and Procedures:**

### **Members 18 years of age or older:**

#### **A. Hormone Therapy**

1. The individual must have a diagnosis of gender dysphoria.
2. The individual must be age of majority. In California, the age of majority is 18 years.
3. The individual must be able to provide informed consent.  
Feminizing/masculinizing hormone therapy may lead to irreversible physical changes and/or adverse effects. The individual must have the capacity to make a fully informed decision to consent to treatment. This should include a discussion regarding physical effects of hormone therapy, medical risks, and options for fertility preservation.
4. It is recommended that the individual be in therapy with a mental health professional.
  - a. The mental health professional must have at a minimum a master's degree or its equivalent in a clinical behavioral science field by an accredited institution, an up-to-date clinical license, training, continuing education and experience working with the diagnosis and treatment of gender dysphoria.
5. The medical provider prescribing the gender-affirming hormones may be a Primary Care Physician, an Obstetrician-Gynecologist, an Endocrinologist, or another medical professional with a license to prescribe hormones.
  - a. The goal of trans-feminizing hormone therapy is the development of female secondary sex characteristics, and suppression/minimization of male endogenous secondary sex characteristics.
  - b. The goal of trans-masculinizing hormone therapy is the development of male secondary sex characteristics, and suppression/minimization of female endogenous secondary sex characteristics.

#### **B. Chest and Genital Gender-Affirming Surgical Consultation:**

1. The individual must have a diagnosis of persistent gender dysphoria or meet the statutory criteria for reconstructive surgery.
2. The individual must be age of majority. In California, the age of majority is 18 years.
3. The individual must be able to provide informed consent. Feminizing/masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment.
4. A Medical Evaluation Form is to be completed (Attachment A). Alternatively, the Provider may submit the same content in the clinical documentation.
5. The Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (Attachment B). Alternatively, a letter from the Therapist addressing the same content as Attachment B is acceptable.
  - a. **One form/letter (for chest surgeries)** from a mental health professional endorsing the request in writing is required for the following chest surgeries:
    - i. (M to F) Augmentation mammoplasty;
    - ii. (F to M) Mastectomy with male chest reconstruction.
  - b. **Two forms/letters (for genital surgeries)** from mental health professionals

endorsing the request in writing are required for the following genital surgeries:

- i. (M to F) Penectomy, orchiectomy, vaginoplasty, colovaginoplasty, clitoroplasty, vulvoplasty, and labioplasty;
  - ii. (F to M) Hysterectomy, salpingo-oophorectomy, urethorplasty, metoidioplasty, phalloplasty, vaginectomy, scrotoplasty, penile implant, testicular prosthesis.
6. For all genital surgeries, the individual must have undergone 12 months of continuous hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual.)
  7. For vaginoplasty, metoidioplasty, and phalloplasty, the individual must have been living in the gender role congruent with the patient's gender identity for 12 continuous months.
  8. It is strongly recommended that a social health assessment that screens the Member for social needs such as housing, food, transportation, and other basic needs be completed by the Provider. IEHP's Social Health Survey (Transgender Pre-Operative Assessment) can be accessed at <https://ww3.iehp.org/en/providers/special-programs/iehp-gender-health/> and click on IEHP Social Health Survey.
  9. Although not explicit criterion, it is recommended that male to female patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

### **C. Penile Prosthesis Requests:**

IEHP will review requests on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity. Penile prosthesis requests require:

1. Completion of genital gender-affirming surgery consultation
2. Status of phalloplasty:
  - a. Approved request for phalloplasty surgical procedure; OR
  - b. Completion of phalloplasty surgical procedure
3. Documentation of:
  - a. Inability to achieve insertive coitus; AND
  - b. Tried and failed external penile rigidity device (e.g. penile splint)

### **D. Other Gender-Affirming Surgical Interventions:**

#### **1. Facial Surgical Consultation:**

- a. The individual must have a diagnosis of persistent gender dysphoria or meet the statutory criteria for reconstructive surgery.
- b. The individual must be 18 years of age or older. In California, the age of majority is 18.
- c. The individual must be able to provide informed consent;
  - i. Feminizing/Masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment.
  - ii. The treating surgeon must show that the individual has received appropriate education prior to the proposed procedure.
- d. Member has lived as the preferred gender for 12 continuous months.
- e. A Medical Evaluation Form is to be completed (Attachment A).  
Alternatively, the Provider may submit the same content in the clinical

documentation.

- f. The Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (Attachment B). Alternatively, a letter from the Therapist addressing the same content as Attachment B is acceptable.
  - i. The form/letter must evaluate facial feature(s) that cause persistent gender dysphoria or meet the statutory criteria for reconstructive surgery, clarify goals and expectations, and assess self-acceptance, AND
  - ii. Address how the presence of stated feature(s) impair function in relation to activities of daily living, AND
  - iii. Address how reconstruction of said features will improve quality of life and daily function.

**2. Facial Surgery requests:**

- a. All components of facial surgery consultation requests have been completed.
- b. Clear documentation of proposed facial surgery procedures with evidence, to include photos, justifying medical necessity and/or reconstructive purpose of requested surgical procedure.
- c. Cosmetic services are not a covered benefit.

**3. Revisions of Gender-Affirming Surgery Requests:**

IEHP authorizes requests for surgical revision on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity to treat gender dysphoria and/or reconstructive surgery. IEHP does not cover cosmetic surgery.

Clinical documentation must support medical necessity to treat gender dysphoria or reconstructive surgery. Surgical revision requests require:

- a. Medical and/or functional complications of prior gender-affirming procedure.
  - b. Measurements and/or photographs of deformity/asymmetry (if applicable).
  - c. Endorsement of medical necessity or reconstructive purpose from the performing surgeon.
4. It is strongly recommended that a **social health assessment** that screens the Member for social needs such as housing, food, transportation, and other basic needs be completed by the Provider prior to proceeding with all surgical interventions. IEHP's Social Health Survey (Transgender Pre-Operative Assessment) can be accessed at <https://ww3.iehp.org/en/providers/special-programs/iehp-gender-health/> and click on IEHP Social Health Survey.

**E. Medically Necessary Durable Medical Equipment (DME) Items:**

1. The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain. Prescribed DME items may be covered as medically necessary only to preserve bodily function essential to activities of daily living or to prevent significant physical disability.
  - a. Chest binders are used by transgender men to alleviate disabling symptoms of gender dysphoria and improve activities of daily living. Chest binder use may obviate the need to proceed with gender-affirming surgery. As such, chest binders are a medically necessary DME item and will be allowed with a frequency limit of 3 (three) every 6 (six) months.
  - b. Vaginal dilation protocols are a required part of the post-operative treatment plan for transgender women who have undergone vaginoplasty. As such, vaginal dilators are a medically necessary DME item in order to ensure an optimal post-operative course and are allowed one time per Member.

- F. Please refer to *UM Subcommittee Approved Guideline- Hair Removal* for hair reduction consultation and procedure authorization criteria.

**For Members under 18 years of age:<sup>1</sup>**

**A. Hormone Therapy**

1. The individual must have a diagnosis of gender dysphoria.
2. It is strongly recommended that the individual be in therapy with a mental health professional.
  - a. The mental health professional must have at a minimum a master's degree or its equivalent in a clinical behavioral science field by an accredited institution, an up-to-date clinical license, and training in childhood and adolescent developmental psychopathology.
3. Puberty-Suppressing Hormone therapy requires a referral with the following information:
  - a. Demonstration of long-lasting and intense pattern of gender non-conformity or gender dysphoria.
  - b. Gender dysphoria emerged or worsened with onset of puberty.
  - c. Coexisting psychological, medical, or social problems that could interfere with treatment have been addressed.
  - d. Because the individual has not reached the age of consent (18 years of age in California), informed consent has been obtained from the parent or other caretaker or guardians.
  - e. Puberty-suppression hormone therapy typically is provided at Tanner level 2 development.
4. Feminizing/Masculinizing Hormone therapy requires:
  - a. Demonstration of long-lasting and intense pattern of gender non-conformity or gender dysphoria.
  - b. Gender dysphoria emerged or worsened with onset of puberty.
  - c. Coexisting psychological, medical, or social problems that could interfere with treatment have been addressed.
  - d. For members under 18 years of age with sufficient mental capacity to give informed consent.
    - i. Feminizing/Masculinizing Hormone therapy prior to age 18 years may be granted on a case-by-case review with medical justification that benefits outweigh the risks.
  - e. Because the individual has not reached the age of consent (18 years of age in California), informed consent has been obtained from the parent or other caretaker or guardians. This should include a discussion regarding physical effects of hormone therapy, medical risks and options for fertility preservation.
5. The medical provider prescribing the gender-affirming hormones may be a Pediatrician or other PCP, an Endocrinologist, or another medical professional with a license to prescribe hormones.
  - a. The goal of trans-feminizing hormone therapy is the development of female secondary sex characteristics, and suppression/minimization of male

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<sup>1</sup> Gender-affirming care for transgender youth is a young and rapidly evolving field. In the absence of solid evidence, Providers must rely on expert opinion. This guideline is largely based on expert opinion from the fields of adolescent medicine, pediatric endocrinology, family medicine, and advanced practice nursing who have many years of expertise in clinical care and research.

- endogenous secondary sex characteristics.
- b. The goal of trans-masculinizing hormone therapy is the development of male secondary sex characteristics, and suppression/minimization of female endogenous secondary sex characteristics.

**B. Gender-affirming surgical therapy for Members younger than 18 years:**

1. Genital surgery is not covered for Members younger than 18 years of age;
2. Chest surgery is covered in transgender female to male Members younger than 18 years of age based on the following criteria:
  - a. 1 year of testosterone treatment, and
  - b. Living in preferred gender for ample amount of time;
  - c. The individual must have a diagnosis of persistent gender dysphoria or meet the statutory criteria for reconstructive surgery;
  - d. Informed consent is obtained. Feminizing/masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment. Because the individual has not reached the age of consent (18 years of age in California), informed consent has been obtained from the parent or other caretaker or guardians.
  - e. A Medical Evaluation Form is to be completed (see Attachment A). Alternatively, the Provider may submit the same content in the clinical documentation;
  - f. The Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (see Attachment B). Alternatively, a letter from the Therapist addressing the same content as Attachment B is acceptable.
    - i. **One form/letter (for chest surgeries)** from a mental health professional endorsing the request in writing is required for (F to M) mastectomy with male chest reconstruction.
3. All other transgender surgery requests for Members younger than 18 years of age will be reviewed for medical necessity to treat gender dysphoria, or to determine if they meet the statutory criteria for reconstructive surgery, on a case by case basis.
4. It is strongly recommended that a **social health assessment** that screens the Member for social needs such as housing, food, transportation, and other basic needs be completed by the Provider prior to all surgical interventions. IEHP's Social Health Survey (Transgender Pre-Operative Assessment) can be accessed at <https://ww3.iehp.org/en/providers/special-programs/iehp-gender-health/> and click on IEHP Social Health Survey.

**Covered Gender-Affirming Surgery:**

1. Hysterectomy
2. Salpingo-oophorectomy
3. Urethroplasty
4. Metoidioplasty
5. Phalloplasty
6. Vaginectomy
7. Scrotoplasty
8. Penile Implant
9. Testicular Prosthesis
10. Penectomy
11. Orchiectomy

12. Vaginoplasty
13. Colovaginoplasty
14. Clitoroplasty
15. Vulvoplasty
16. Labiaplasty

**Other Commonly Requested Surgeries (that would be reviewed on a case-by-case basis for medical necessity to treat gender dysphoria or to determine if the statutory criteria for reconstructive surgery is met):**

1. Abdominoplasty
2. Augmentation Mammoplasty
3. Face lift, Blepharoplasty
4. Brow Lift
5. Calf Implants
6. Cheek/Malar Implants
7. Chin/Nose Implant
8. Collagen injections
9. Facial Bone Reconstruction
10. Forehead Lift
11. Hair Removal or Transplant
12. Liposuction
13. Lip Reduction
14. Mastopexy
15. Neck Tightening
16. Pectoral Implants
17. Reduction Thyroid Chondroplasty
18. Removal of Redundant Skin
19. Rhinoplasty
20. Voice Therapy/Voice Lessons
21. Voice Modification Surgery

## **COVERAGE LIMITATIONS AND EXCLUSIONS**

**Coding Issues-** CPT Codes Not Covered:

1. 55970 Intersex surgery, male to female
2. 55980 Intersex surgery, female to male
3. Due to the serial nature of surgery for the gender transition, CPT-4 coding should be specific for the procedures performed during each operation. A Treatment Authorization Request (TAR) is necessary only for procedures that currently require a TAR.

## **ADDITIONAL INFORMATION**

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria. These include:

1. Psychotherapy for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.
2. Changes in gender expression and role.

3. Hormone therapy to feminize or masculinize the body or puberty suppression therapy.
4. Surgery to change primary and/or secondary sex characteristics.

## **CLINICAL/REGULATORY RESOURCE**

### **Centers for Medicare and Medicaid Coverage (CMS), National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9)**

CMS determined that no national coverage determination (NCD) is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with gender dysphoria. Coverage determination will continue to be made by the local Medicare Administrative Contractor (MAC) on a case-by-case basis.

### **Medi-Cal (2020):**

Treatment for gender dysphoria is a covered Medi-Cal benefit when medically necessary.

### **Department of Health Care Services, All Plan Letter 20-018:**

The purpose of this All Plan Letter (APL) is to remind Medi-Cal managed care health plans (MCPs) that they must provide covered services to all Medi-Cal beneficiaries, including transgender beneficiaries.

### **World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7 - WPATH (2012):**

The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health.

## **DEFINITION OF TERMS**

Gender dysphoria: Discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth.

## **REFERENCES**

1. AETNA. 2013 "Clinical Policy Bulletin: Gender Reassignment Surgery."
2. American Psychiatric Association. 2013. Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> edition). Arlington, VA: American Psychiatry Publishing.
3. California Family Code Sections 6926, 6927, 6929. Accessed on February 2, 2021 at: [http://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=6924.&lawCode=FAM](http://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=6924.&lawCode=FAM)
4. California Health and Safety Code, Section 1367.63, 1999. Accessed February 1, 2021 at: [https://california.public.law/codes/ca\\_health\\_and\\_safety\\_code\\_section\\_1367.63](https://california.public.law/codes/ca_health_and_safety_code_section_1367.63)
5. Centers for Medicare & Medicaid Services, 2016 "National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9), 2016
6. CIGNA. 2012 "Medical Necessity Guidelines: Gender Reassignment Surgery."
7. Department of Health Care Services (DHCS), State of California-Health and Human Services Agency. October 26, 2020. All Plan Letter 20-018, Ensuring Access to Transgender Services
8. Deutsch, Madeline, 2016. "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," Center of Excellence for Transgender Health, Department of Family & Community Medicine, UCSF, 2<sup>nd</sup> edition, June 17, 2016.



9. Medi-Cal Provider Manual. 2020. Transgender Services. Accessed February 1, 2021 at <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/transgender.pdf>
10. Medi-Cal Provider Manual, 2020. Durable Medical Equipment (DME): An Overview. Accessed February 1, 2021 at: <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/dura.pdf>
11. Medical Board of California, Frequently Asked Questions – Cosmetic Treatments, accessed on September 13, 2018 at: [http://www.mbc.ca.gov/Licensees/Cosmetic\\_Treatments\\_FAQ.aspx](http://www.mbc.ca.gov/Licensees/Cosmetic_Treatments_FAQ.aspx)
12. San Francisco Department of Public Health, accessed at <https://www.sfdph.org/dph/comupg/oprograms/THS/eligibility.asp> on 09/19/2016.
13. San Francisco Health Plan, accessed at <https://www.sfdph.org/dph/files/THS2/SFHP-MedicalCriteriaTransgenderCare-020215.pdf> on April 29, 2017
14. Title 42 USC 1396d(r)(5) available to view at <https://uscode.house.gov/view.xhtml?req=1396d&f=treesort&fq=true&num=60&hl=true&edition=prelim&granuleId=USC-prelim-title42-section1396d>
15. United Healthcare. “Reimbursement Policy: Transsexual Surgery.” 2014
16. Welfare and Institutions Code section 14059.5 available to view at [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14059.5](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14059.5).
17. WPATH Standards of Care Revision Committee. 2011. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, 7<sup>th</sup> version. World Professional Association for Transgender Health. Accessed January 26, 2021 at <https://www.wpath.org/publications/soc>
18. Wylie, et al., Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *J Clin Endocrinol Metab*, November 2017, 102(11):3869-3903.

## **DISCLAIMER**

IEHP Clinical Authorization Guidelines (CAG) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Authorization Guidelines (CAG) express IEHP's determination of whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. IEHP has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). IEHP makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Authorization Guidelines (CAG). IEHP expressly and solely reserves the right to revise the Clinical Authorization Guidelines (CAG), as clinical information changes.

**ATTACHMENT A**

**Transgender Health Services Medical Evaluation Form**

Member's current Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member's name on file with insurance, if different: \_\_\_\_\_

Hormone Therapy History      Mark only one "Yes":

**Yes**

- This Member has taken 12 continuous months of hormone therapy as appropriate to the Member's gender goals, **OR**
- Hormone therapy is not appropriate for this Member's gender goals, **OR**
- This Member has medical contraindications to hormones therapy, **OR**
- This Member is unable or unwilling to take hormone therapy

**Please mark either "Yes" or "No" for every item on the rest of the document. All items must be completed.**

**Yes      No**

- This Member has gender dysphoria

**Medical conditions that could interfere with expected outcomes of proposed surgery**

**Yes      No**

**Yes      No**

- |                          |                          |  |                          |                          |                                      |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Uncontrolled diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | History of venous thromboembolism    |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Active infection</b>                  | <input type="checkbox"/> | <input type="checkbox"/> | <b>History of poor wound healing</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Severe immunosuppression</b>          | <input type="checkbox"/> | <input type="checkbox"/> | <b>Obesity BMI: _____</b>            |
| <input type="checkbox"/> | <input type="checkbox"/> | Other unstable medical conditions: _____ |                          |                          |                                      |

**Other Conditions**

**Yes      No**

**Yes      No**

- |                          |                          |                        |                          |                          |                                 |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco/nicotine use   | <input type="checkbox"/> | <input type="checkbox"/> | Other significant substance use |
| <input type="checkbox"/> | <input type="checkbox"/> | Cannabis/marijuana use |                          |                          |                                 |

If any medical condition present please document plans to stabilize, including a cessation plan if Member uses nicotine:

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- | <b>Yes</b>               | <b>No</b>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Medical conditions are well controlled  |
| <input type="checkbox"/> | <input type="checkbox"/> | This Member has been engaged in appropriate medical care for at least 1 year demonstrating adherence to laboratory monitoring and compliance with prescribed medications, treatments, and appointments. |
| <input type="checkbox"/> | <input type="checkbox"/> | It is my opinion that the proposed surgery will benefit this Member's health  |

**Medical Provider Name**

**Signature**

**Date**

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Please fax form with surgical procedure referral authorization request to IEHP at (909) 890-5751.



**ATTACHMENT B**

**Therapist Documentation Form for Evaluation for Transgender Surgery**

Member's Name:

Legal Name:

DOB:

Clinician Name:

Office location or clinic:

Please describe your experience completing assessments for gender related surgeries:

For which surgery or surgeries are you referring this Member?

- Orchiectomy
- Penectomy
- Vaginoplasty
- Hysterectomy/Oophorectomy
- Phalloplasty
- Metoidioplasty
- Vulvoplasty/Labiaplasty
- Feminizing Mammoplasty (breast augmentation)
- Subcutaneous Mastectomy with male chest reconstruction
- Surgery not listed here. Please describe:

Please list the dates that you evaluated this Member for readiness and appropriateness for surgical intervention?

Which current or previous medical and/or mental health providers did you speak with in your evaluation?

Please give a description of this Member, identify characteristics, their history of gender dysphoria and emphasize their attempts to address their gender dysphoria:

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Please indicate the length of time the Member has taken hormones and their response to hormones?

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For Members considering Vaginoplasty, Metoidioplasty, and Phalloplasty: The Standards of Care state that the Member must have “12 continuous months of living in a gender role that is congruent with their gender identity.” Please describe how the Member has met this standard:

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Does this Member have the capacity to give informed consent for genital surgery? If no, please explain:

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Are their issues the surgeons need to know about regarding communication? These could include English fluency, hearing impairments, an autism spectrum disorder, literacy level, learning differences, etc:

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How will surgery improve this Member’s functioning? How will it make their life better? Please use the Member’s words:

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Do you have any hesitation or concern that the Member may regret or not benefit from a surgical intervention?

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Please give a brief description of this Member's mental health history, including suicidality, homicidality, and any history of violence towards healthcare workers, any psychiatric hospitalizations, and residential treatment for mental health or substance use:

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Please list all current and past mental health diagnoses:

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Please list all medications that the Member is currently taking related to psychological concerns, sleep, or emotional problems (this should include supplements, like St. John's Wort and medical marijuana). Please list the prescriber's name next to the medication:

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Does this Member have a mental health problem that the stress of surgery, anesthesia, or recovery may result in decompensation? For instance, PTSD, anxiety disorders, schizophrenia, substance abuse, etc.:

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Please describe how you have prepared this Member for this possibility and how it will be addressed:

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Please describe current and past substance use including nicotine. Please list any concerns the Member has regarding their substance use or their sobriety and pain medication:

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Please describe medical problems the Member may have:

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What is your assessment of this Member's function, including their ability to satisfactorily complete ADL's and IDL's (Activities of Daily Living and Instrumental Activities of Daily Living):

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Describe this Member's support system, relationships, family support and work:

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Do you believe this Member is capable of carrying out their aftercare plan? (Including providing for their own self-care following surgery; e.g. dilation 3x per day, hygiene issues, monitoring for infections, getting adequate nutrition, staying housed, etc.) Yes  No

What additional care will this Member need and how will that be arranged? Who will provide needed case management?

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Your rationale for the referral for surgery:

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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. (CA Health & Safety Code § 1367.63)

Would the requested surgery be considered reconstructive? Please explain.

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Is the Member's gender identity stable and consolidated? Yes  No

Do you believe the Member has realistic expectations about what the surgery can and cannot do?

Yes  No

Is there anything you would like to add?

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Your Name, Title and License:

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Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your phone number for follow up: \_\_\_\_\_

Please print and sign this form:

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Please fax form with surgical procedure referral authorization request to IEHP at (909) 890-5751.