**Facial feminization surgery and chondrolaryngoplasty**

Blue Care Network provides coverage for this procedure for adult BCN HMO University of Michigan members who meet medical necessity criteria. Submit authorization requests through e-referral.

The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and BCN cannot authorize it, BCN will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. Compliance with this prior authorization requirement will be monitored retrospectively.


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See below for the questions you’ll encounter in the e-referral system.

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible answers</th>
</tr>
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<tbody>
<tr>
<td>Does the patient have a persistent, well-documented gender dysphoria manifested by clinically significant distress and by significant functional impairment identified by a detailed psychological assessment by a mental health professional (either psychiatrist, PhD prepared clinical psychologist or master’s level clinician who is licensed to practice independently in their state)?</td>
<td>☑️</td>
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<tr>
<td>Has the patient been previously approved for gender reassignment surgery OR has already had gender reassignment surgery?</td>
<td>☑️</td>
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<tr>
<td>Does the patient have the capacity to make a fully informed decision and to consent for treatment?</td>
<td>☑️</td>
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</tbody>
</table>
See below for the questions you’ll encounter in the e-referral system. (continued)

**Q** Does the patient have any significant medical or mental health concerns which are not controlled? MUST select N/A if no conditions exist.

**A** Possible answers:
- ☐ History of issues addressed and in full remission
- ☐ Active issues; undergoing adequate active treatment currently
- ☐ Active issues; not being adequately treated currently
- ☐ N/A (Must select N/A if no conditions exist.)

**Q** Has the patient received 12 continuous months of hormone therapy with estrogen, unless contraindicated or not tolerated?

**A** Possible answers: ☐ Yes ☐ No ☐ N/A

**Q** Has the patient been living as a woman for 12 continuous months?

**A** Possible answers: ☐ Yes ☐ No ☐ N/A