WSR 24-21-072
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed October 14, 2024, 10:27 a.m., effective November 14, 2024]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (agency) is revising these rules to align with current standards of care and to clarify some subsections of this rule.

Citation of Rules Affected by this Order: Amending WAC 182-531-1675.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 24-15-152 on July 24, 2024.

Changes Other than Editing from Proposed to Adopted Version:

Proposed/Adopted	WAC Subsection	Reason
WAC 182-531-1675 (1)(i)		
Proposed	**Reversal procedures.**The agency does not cover procedures and surgeries related to reversal of anygender affirming surgery.	Removed in response to stakeholder concerns about excluding reversal procedures.
Adopted	This language has been removed.	
WAC 182-531-1675 (d)(i)		
Proposed	(d)**Requirements for hair removal.**For facial or body hair removal, a client must submit: (i) A letter written within the past 18 months from the provider managing the client's gender-affirming hormone therapy: (A) Describing the client's attempted hair removal techniques that failed, for each affected part of the body; and (B) Identifying the medical condition that prevents the client from shaving or using other hair removal techniques, such as documented folliculitis, documented sensitivity to hair removal techniques, or thick, male-pattern hair growth that prohibits adequate hair removal.	Removed WAC 182-531-1675 (d)(i)(B) to make the rules consistent with RCW 74.09.675.
Adopted	(d)**Requirements for hair removal.**For facial or body hair removal, a client must submit: (i) A letter written within the past 18 months from the provider managing the client's gender-affirming hormone therapy describing the client's attempted hair removal techniques that failed, for each affected part of the body.	

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 14, 2024.

Wendy Barcus
Rules Coordinator

OTS-5495.2

AMENDATORY SECTION (Amending WSR 23-03-071, filed 1/13/23, effective 2/13/23)

WAC 182-531-1675 Washington apple health—Gender affirming interventions for gender dysphoria. (1) **Overview of treatment program.**

(a) **Medicaid agency coverage.** The medicaid agency covers the services listed in (b) of this subsection to treat gender dysphoria (also referred to as gender incongruence) under WAC 182-501-0050 and 182-531-0100. These services include life-changing procedures that may not be reversible.

(b) **Medical services covered.** Medical services covered by the agency include, but are not limited to:

(i) Presurgical and postsurgical hormone therapy;

(ii) Puberty suppression therapy;

(iii) Behavioral health services; ((~~and~~))

(iv) Gender affirming hair removal services; and

(v) Surgical and ancillary services including, but not limited to:

(A) Anesthesia;

(B) Labs;

(C) Pathology;

(D) Radiology;

(E) Hospitalization;

(F) Physician services; and

(G) Hospitalizations and physician services required to treat postoperative complications of procedures performed under this section.

(c) ((**~~Surgical services covered.~~** ~~Surgical services to treat gender dysphoria are a covered service for clients who have~~)) **Diagnosis of gender dysphoria/gender incongruence.** A diagnosis of gender dysphoria/gender incongruence is required to obtain services under this program and must be made by a provider who meets the qualifications outlined in chapter 182-502 WAC.

(d) **Medical necessity.** ((~~Under this program,~~)) The agency authorizes and pays for only medically necessary services. Medical necessity is defined in WAC 182-500-0070 and is determined under WAC 182-501-0165 and limitation extensions in accordance with WAC 182-501-0169.

(e) **Provider requirements.** Providers should be knowledgeable of gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria/gender incongruence, including experience utilizing standards of care that include the World Professional Association for Transgender Health (WPATH) Standards of Care.

(f) **Clients age ((~~twenty~~)) 20 and younger.** The agency evaluates requests for clients age ((~~twenty~~)) 20 and younger according to the early and periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC. Under the EPSDT program, the agency pays for a service if it is medically necessary, safe, effective, and not experimental.

(g) **Transportation services.** The agency covers transportation services under the provisions of chapter 182-546 WAC.

(h) **Out-of-state care.** Any out-of-state care, including a presurgical consultation, must be prior authorized as an out-of-state service under WAC 182-501-0182.

(i) ((**Reversal procedures.** ~~The agency does not cover procedures and surgeries related to reversal of gender affirming surgery.~~

~~(j)~~)) **Corrective surgeries for intersex traits.** The agency covers corrective or reparative surgeries for people with intersex traits who received surgeries that were performed without the person's consent.

(2) **Prior authorization.**

(a) **Prior authorization requirements for surgical services.** As a condition of payment, the agency requires prior authorization for all surgical services to treat gender ((~~dysphoria, including modifications to, or complications from, a previous surgery~~)) dysphoria/gender incongruence, except as provided in subsection (3) of this section. This includes modifications or revisions to, or correcting complications from, a previous surgery related to infections or impairment of a function.

(b) **Required documentation.** The provider must include the following documentation with the prior authorization request:

(i) ((**~~Two psychosocial evaluations required.~~**)) **Behavioral health assessment.** Documentation of ((~~two separate psychosocial evaluations~~)) a behavioral health assessment performed within 18 months preceding surgery by ((~~two separate~~)) a qualified ((~~mental~~)) behavioral health professional((~~s~~)) as defined in WAC 182-531-1400. ((~~These providers~~)) This provider must be a licensed health care professional((~~s~~)) who ((~~are~~)) is eligible under chapter 182-502 WAC, as follows:

(A) Psychiatrist;

(B) Psychologist;

(C) Psychiatric advanced practice registered nurse ((~~practitioner (ARNP)~~)) (APRN);

(D) Psychiatric mental health nurse practitioner-board certified (PMHNP-BC);

(E) Mental health counselor (LMHC);

(F) Independent clinical social worker (LICSW);

(G) Advanced social worker (LASW); or

(H) Marriage and family therapist (LMFT).

(ii) ((**~~One psychosocial evaluation for top surgery.~~** ~~For top surgery with or without chest reconstruction, the agency requires only one comprehensive psychosocial evaluation.~~

~~(iii)~~)) **Evaluation requirements.** ((~~Each~~)) The comprehensive ((~~psychosocial evaluation~~)) behavioral health assessment must:

(A) Confirm the diagnosis of gender dysphoria, or gender incongruence, or both, as defined by the *Diagnostic Statistical Manual of Mental Disorders;*

(B) Document that:

(I) ((~~The client has:~~

~~• Lived for 12 continuous months in a gender role that is congruent with their gender identity, except for top surgery, hysterectomy, or orchiectomy; or~~

~~• Been unable to live in their gender identity due to personal safety concerns.~~

~~(II) The client has been evaluated for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed.~~

~~(iv)~~)) The client's experience of gender incongruence is marked and sustained;

(II) The client has the desire to make their body as congruent as possible with a desired gender through surgery, hormone treatment, or other medical therapies;

(III) Gender incongruence causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

(IV) The client has no contraindicating behavioral health conditions that would impair the ability to give informed consent, as described in (c) of this subsection. If a client has a behavioral health condition that interferes with their ability to give informed consent and the client understands the risks, benefits, and alternatives to gender affirming treatment, the provider must facilitate treatment of the underlying behavioral health condition to support the client's ability to provide informed consent.

(iii) **Hormone therapy.** Documentation from the primary care provider or the provider prescribing hormone therapy that the client has:

(A) As appropriate to the client's gender goal for the following procedures:

(I) Had ((~~12~~)) six continuous months of hormone therapy immediately preceding ((~~the~~)) a request for genital surgery((~~, as appropriate to the client's gender goals,~~)); or

(II) Twelve continuous months of continuous hormone therapy immediately preceding a request for breast augmentation surgery, unless:

• Hormones are not clinically indicated for the ((~~individual, with the exception of~~)) client or hormones are not aligned with the client's gender health care plan, or both; or

• The client has requested a mastectomy or reduction mammoplasty((~~, which do not require hormone therapy~~)); or

((~~(B)~~)) • The client has a medical contraindication to hormone therapy; and

((~~(C)~~)) • The client has a medical necessity for surgery and ((~~that~~)) the client is adherent with current gender dysphoria treatment.

((~~(v)~~)) (B) Gender dysphoria/gender incongruence that is not a symptom of another medical condition; and

(C) Had no medical conditions that would impair the client's ability to give informed consent.

(iv) **Surgical.** Documentation from the surgeon of the client's:

(A) Medical history and physical examination(s) performed within the 12 months preceding surgery;

(B) Medical necessity for surgery and surgical plan; and

(C) For hysterectomies, a completed agency hysterectomy consent form must be submitted.

(c) **Informed consent.** The surgeon must provide documentation showing that they informed the client of:

(i) The nature of the proposed care, treatment, services, medications, and procedures;

(ii) Potential benefits, risks, or side effects, including potential problems that might occur during recuperation;

(iii) The likelihood of achieving the client's treatment goals;

(iv) Reasonable alternatives;

(v) Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services;

(vi) Any limitations on the confidentiality of information learned from or about the patient;

(vii) The effect of gender-affirming treatment on reproduction; and

(viii) Reproductive options before having gender-affirming surgeries that have the potential to create iatrogenic infertility.

(d) **Requirements for hair removal.** For facial or body hair removal, a client must submit:

(i) A letter written within the past 18 months from the provider managing the client's gender-affirming hormone therapy describing the client's attempted hair removal techniques that failed, for each affected part of the body.

(ii) A letter of medical necessity from the client's dermatologist or primary care provider written within the past 18 months that includes:

(A) The size and location of the area to be treated; and

(B) For each area of the body, the number of expected units needed to complete treatment.

(iii) Photographs of the areas to be treated, if requested by the agency.

(e) **Other requirements.** If the client fails to complete all of the requirements in ((~~subsection (2)~~))(b) of this ((~~section~~)) subsection, the agency will not authorize gender affirming surgery unless:

(i) The clinical decision-making process is provided in the referral letter and attachments described in ((~~subsection (2)~~))(b) of this ((~~section~~)) subsection; and

(ii) The agency has determined that the request is medically necessary in accordance with WAC 182-501-0165 based on review of all submitted information.

((~~(d)~~)) (f) **Behavioral health provider requirements.** The behavioral health provider((~~s~~)) who performs the ((~~psychosocial evaluation~~)) behavioral health assessment described in ((~~subsection (2)~~))(b)(i) of this ((~~section~~)) subsection must:

(i) Meet the provisions of WAC 182-531-1400;

(ii) Be competent in using the *Diagnostic Statistical Manual of Mental Disorders*, and the *International Classification of Diseases* for diagnostic purposes;

(iii) Be able to recognize and diagnose coexisting ((~~mental~~)) behavioral health conditions and to distinguish these from gender dysphoria/gender incongruence;

(iv) Be knowledgeable of gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and

(v) Have completed continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a ((~~mental~~)) behavioral health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

((~~(e)~~)) (g) **Clients age 17 and younger.** Clients age 17 and younger must meet the requirements for prior authorization identified in ((~~subsection (2)~~))(a) through (d) of this ((~~section~~)) subsection, except that((~~:~~

~~(i) One of~~)) the comprehensive ((~~psychosocial evaluations~~)) behavioral health assessment required in ((~~subsection (2)~~))(b)(i) of this ((~~section~~)) subsection must be a biopsychosocial behavioral health assessment performed by a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.

((~~(ii) For top surgery with or without chest reconstruction, the agency requires only one comprehensive psychosocial evaluation from a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.~~))

(3) **Expedited prior authorization (EPA).**

(a) **Approved EPA procedures.** The agency allows a provider to use the EPA process for clients age 17 and older for the following medically necessary procedures:

(i) Bilateral mastectomy or reduction mammoplasty with or without chest reconstruction; and

(ii) Genital or donor skin graft site hair removal when medically necessary to prepare for genital reassignment.

(b) **Clinical criteria and documentation.** To use the EPA process for procedures identified in (a) of this subsection, the following clinical criteria and documentation must be kept in the client's record and made available to the agency upon request:

(i) One comprehensive ((~~psychosocial evaluation~~)) biopsychosocial behavioral health assessment performed by a licensed behavioral health provider within the 18 months preceding surgery that meets the requirements identified in subsection (2) of this section;

(ii) Documentation from the primary care provider or the provider prescribing hormone therapy of the medical necessity for surgery and confirmation that the client is adherent with current gender dysphoria treatment; and

(iii) Documentation from the surgeon of the client's:

(A) Medical history and physical examinations performed within the 12 months preceding surgery; and

(B) Medical necessity for surgery and surgical plan.

(c) **Documentation exception.** When the requested procedure is for genital or donor skin graft site hair removal to prepare for bottom surgery, there is an exception to the requirements in (b) of this subsection. The only documentation required is either a:

(i) Letter of medical necessity from the treating surgeon that includes the size and location of the area to be treated, and expected date of planned genital surgery; or

(ii) Letter of medical necessity from the provider who will perform the hair removal that includes the surgical consult for bottom surgery and addresses the need for hair removal prior to gender affirming surgery.

(d) **Prior authorization required for other surgeries.** All other surgeries to treat gender dysphoria, including modifications to, or complications from a previous surgery require prior authorization to determine medical necessity.

(e) **Recoupment.** The agency may recoup any payment made to a provider for procedures listed in this subsection if the provider does not follow the EPA process outlined in WAC 182-501-0163 or if the provider does not maintain the documentation required by this subsection.