UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

Facial Gender Affirmation Surgery (FGAS)

The Comprehensive Gender Services Program (CGSP) uses the World Professional Association for Transgender Health (WPATH) Standards of Care guidelines when referring you for care relating to gender dysphoria, including facial gender affirmation surgery. The process described in this handout helps us to make sure that we follow the WPATH Standards of Care guidelines and give you safe and effective care.

What are the requirements for facial gender affirmation surgery (FGAS)?

Facial gender affirmation surgery (FGAS) refers to a group of surgeries that change the features of a person's face (like the chin, jawline, cheekbones, and forehead) to better align with their gender identity.

- To have this surgery, you will need **1 support letter** from a licensed mental health care provider that addresses the WPATH Standards of Care guidelines.
- Before you move forward with surgery, you may need to be using **hormone replacement therapy (HRT).** Some insurance providers require 6 or 12 months of HRT before they will authorize (approve) and cover (pay for) the surgery.

Will my insurance plan cover FGAS?

The following insurance providers seem to have added coverage for FGAS to their standard policies:

- Blue Cross Blue Shield of MI (including Blue Care Network and Blue Cross Complete) – requires 12 months of HRT
- Blue Cross Blue Shield FEP – requires 6 months of HRT

- Some out-of-state Blue Cross Blue Shield (BCBS) providers (like Anthem BCBS, Empire BCBS, and Independence BCBS) – may require HRT
- HAP – requires 12 months of HRT, only covers facial feminization (not facial masculinization)
- Meridian – requires 6 months of HRT
- UnitedHealthcare commercial plans – covers tracheal shave surgery only

This list of insurance providers may be incomplete. CGSP will continue to update this list as we gather further information.

If your insurance provider is on this list, it is not a guarantee that your surgery will be approved and covered by your insurance plan. Similarly, if your insurance plan is not on this list, it is not a guarantee that insurance coverage for your surgery will be denied. Insurance plans can change which procedures are covered, so we recommend that you contact your insurance provider or look at your insurance plan documents for information about what your personal plan can cover.

After your surgery consultation appointment, you will talk with your surgery scheduler about the process of getting your surgery authorized by your insurance plan and what it means if that authorization is approved or denied.

What happens if my insurance plan doesn't cover FGAS?

- If your insurance plan does not cover the surgery, we suggest speaking with University of Michigan Health's patient financial counselors. They can get you a cost estimate (tell you about how much the surgery will cost) and talk with you about possible financial assistance (resources to help with paying for the surgery). You can call them Monday through Friday between 8:00 AM – 4:00 PM at (734) 232-2621.

- If you decide to have the surgery, our patient financial counselors can also work with you on a payment plan for the **out-of-pocket costs** (the costs that your insurance won't pay for).
- You will still need 1 support letter from a mental health care provider.

What are my next steps to get a support letter for FGAS?

1. Meet with a **licensed mental health care provider** to get a support letter. We still recommend that you get a support letter from a mental health care provider (instead of your primary care provider or hormone care doctor), because it has been our experience that letters from mental health care providers are more successful with getting insurance coverage.
    - Licensed mental health care providers include:
        - Psychologists
        - Clinical social workers
        - Professional counselors
        - Marriage and family therapists
        - Psychiatrists or psychiatric nurse practitioners
    - If your letter writer has a limited license, their fully licensed supervisor needs to co-sign their letter.
    - If you would like help finding a licensed mental health care provider who is able to write your support letter, please call the CGSP office at (734) 998-2150.
2. Send the support letter to our office (either you or your letter writer can send it) in one of the following ways:
    - **Mail:** CGSP, 4250 Plymouth Rd, SPC 5766, Ann Arbor, MI, 48109
    - **Fax:** (734) 998-2152
    - **E-mail:** GenderServices@med.umich.edu
3. Once you or your letter writer have sent the letter to CGSP, we recommend that you call the CGSP office to make sure that we received

the letter and to schedule the date of your consultation appointment with the surgeon.

If you or your letter writer have any questions or concerns about the letter-writing or letter-reviewing process, please call our office at (734) 998-2150.

What information does my mental health care provider need to include in my support letter?

- Our list of guidelines is included at the end of this packet. Please give this list to the licensed mental health care provider who will write your support letter, especially if they don't know the WPATH Standards of Care. If they have any other questions about what to include in the letter, please have them contact the CGSP office at (734) 998-2150.
- The guidelines we use to determine if your letter is complete are based on the WPATH Standards of Care. The places where our guidelines are different from WPATH are related to requirements from insurance providers and to medical concerns from our surgical teams.

What happens after I send my support letter to CGSP?

- Once we get your support letter, you can schedule your consultation appointment with a surgeon for FGAS. If you have a patient portal account set up, you will receive a message from our team to let you know that your letter has been received. If you do not have an account, we will call you instead.
- Before you come in for your appointment with the surgeon, the CGSP team will review your letter to make sure that it addresses the WPATH Standards of Care guidelines. We will respond in one of 2 ways once we review your support letter:
    - If the support letter does not address the WPATH Standards of Care guidelines, or if we have questions about the support letter,

we will contact your letter writer. It's important that your letter writer talks with our office about the letter so that they can update the support letter as needed.

- If there are no issues with your support letter, we will contact you (by phone or through the online patient portal at MyUofMHealth.org) to let you know that your letter is complete. If you have not already scheduled your appointment with a surgeon, our message will also include a reminder to do so.

How do I prepare for my surgery consultation appointment?

- Before you come in for your consultation appointment, you must be nicotine-free. This means that **you must stop using all products containing nicotine** (including cigarettes, e-cigarettes or vape pens, nicotine patches, nicotine gum, and chewing tobacco).
- The surgical team may have you tested before scheduling your surgery date to make sure that you don't have nicotine in your body. If your test shows that you have nicotine in your body, your surgery date will not be scheduled at that time. You will likely need to wait 8-12 weeks before we test you again for nicotine.
- If you smoke or vape marijuana, our surgeons also recommend that you stop completely or switch to marijuana products that are not smoked or vaped, such as edibles.

What happens at the surgery consultation appointment?

At the consultation appointment, you will:

- Talk with your surgeon to see if you are a good candidate for surgery (meaning that you are medically ready for FGAS).
- Ask your surgeon questions about the surgery.
- Talk with your surgery scheduler about your next steps, including out-of-pocket costs.

Please note: You will not schedule your surgery date at the consultation appointment.

- If you are planning to use your insurance coverage for your surgery, your surgeon's team will make sure they get insurance pre-authorization for the surgery from your health insurance provider before scheduling the date of surgery. **Insurance pre-authorization** is approval from your health insurance provider that they will cover all or part of the surgery costs. Once the surgery team has gotten insurance pre-authorization for you, you will be able to schedule your breast augmentation.
- If you are not planning to use your insurance coverage for your surgery, a member of the Plastic Surgery team will contact you (through the patient portal or by phone) 1-2 weeks after your consultation appointment to discuss the self-pay costs before they schedule your surgery date.

The Plastic Surgery department team will review the timeline between the consultation appointment and surgery date with you at your consultation appointment.

Who do I contact if I have questions about this process or my letter?

Please contact our office by phone at (734) 998-2150 on Monday through Friday between 8:00 AM – 4:30 PM.

- We can also help your letter writer if they have any questions about the letter writing process and how they can make sure that the support letter addresses the WPATH Standards of Care guidelines.

If you have already had your consultation appointment and you have questions about your next steps after that appointment, please contact the Plastic Surgery clinic directly. They can be reached by phone at (734) 998-6022 on Monday through Friday between 8:00 AM – 4:30 PM.

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