

1 Fennemore Craig, P.C.
 Timothy J. Berg (No. 004170)
 2 Amy Abdo (No. 016346)
 Ryan Curtis (No. 025133)
 3 Shannon Cohan (No. 034429)
 2394 E. Camelback Road, Suite 600
 4 Phoenix, Arizona 85016
 Telephone: (602) 916-5000
 5 Email: tberg@fennemorelaw.com
 Email: amy@fennemorelaw.com
 6 Email: rcurtis@fennemorelaw.com
 Email: scohan@fennemorelaw.com

7 Attorneys for Defendants
 8 State of Arizona, Andy Tobin, and Paul Shannon

9 UNITED STATES DISTRICT COURT
 10 DISTRICT OF ARIZONA

11 Russell B. Toomey,
 12 Plaintiff,
 13 v.
 14 State of Arizona, et al.
 15 Defendants.

No. 4:19-cv-00035

**DECLARATION OF RYAN CURTIS
 IN SUPPORT OF DEFENDANTS
 STATE OF ARIZONA’S, ANDY
 TOBIN’S, AND PAUL SHANNON’S
 OPPOSITION TO PLAINTIFF’S
 MOTION FOR SUMMARY
 JUDGMENT**

16
 17
 18 I, Ryan Curtis, submit this declaration under penalty of perjury pursuant to
 19 28 U.S.C. § 1746 and declare as follows:

20 1. I am a Director at Fennemore Craig, P.C., am licensed to practice law in the
 21 State of Arizona, and am lead counsel for Defendants State of Arizona, Andy Tobin, and
 22 Paul Shannon (collectively, the “State Defendants”).

23 2. I submit this declaration in support of the State Defendants’ Opposition to
 24 Plaintiff’s Motion for Summary Judgment, filed concurrently.

25 3. I base this declaration on my personal knowledge and on information obtained
 26 in the course of the above-captioned matter.

1 4. Attached as **Exhibit A** is a true and correct copy of excerpts of Dr. Russell
2 Toomey’s Deposition Transcript, dated May 26, 2021.

3 5. Attached as **Exhibit B** is a true and correct copy of excerpts of Loren
4 Schechter, M.D.’s Deposition Transcript, dated June 15, 2021.

5 6. Attached as **Exhibit C** is a true and correct copy of AETTOOM000023–39,
6 a document produced by third-party Aetna in response to subpoena duces tecum in this
7 matter.

8 7. Attached as **Exhibit D** is a true and correct copy of BCBSAZ00002137–52,
9 a document produced by third-party BlueCrossBlueShield of Arizona in response to
10 subpoena duces tecum in this matter.

11 8. Attached as **Exhibit E** is a true and correct copy of AZSTATE.153283–96, a
12 document produced by State Defendants in this litigation.

13 9. Attached as **Exhibit F** is a true and correct copy of AZSTATE.153297–310,
14 a document produced by State Defendants in this litigation.

15 10. Attached as **Exhibit G** is a true and correct copy of excerpts of Marie
16 Isaacson’s Deposition Transcript, dated March 26, 2021.

17 11. Attached as **Exhibit H** is a true and correct copy of excerpts of Scott Bender’s
18 Deposition Transcript, dated March 31, 2021.

19 12. Attached as **Exhibit I** is a true and correct copy of excerpts of Elizabeth
20 Schafer’s Deposition Transcript, dated April 28, 2021.

21 13. Attached as **Exhibit J** is a true and correct copy of excerpts of Michael
22 Meisner’s Deposition Transcript, dated March 16, 2021.

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I declare under penalty of perjury that the foregoing is true and correct.
EXECUTED this 26th day of October, 2022.

By: 

Ryan Curtis

28291334

EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Russell B. Toomey,) Case No. CV19-0035-TUC-RM (LAB)
)
Plaintiff,)
)
vs.)
)
State of Arizona, et al.,)
)
Defendants.)
_____)

DEPOSITION OF RUSSELL B. TOOMEY, Ph.D.

Phoenix, Arizona
May 26, 2021
9:00 a.m.

REPORTED BY:
JENNIFER HANSSEN, RPR
Certified Reporter
Certificate No. 50165

PREPARED FOR:
CONDENSED/ASCII

(Certified Copy)

1 Q. And why did you think it was important to be in
2 compliance with WPATH's standards?

3 A. Because those are the standards of care.

4 Q. Put out by WPATH; correct?

5 A. Yes.

6 Q. And do you believe that the entire medical
7 community follows WPATH?

8 A. No.

9 Q. How did you find EJ Millstone?

10 A. I found her when I was looking for a counselor
11 who was knowledgeable about trans populations in 2016.

12 Q. Did you find her yourself or did someone give
13 you a referral?

14 A. I believe I was given a referral.

15 Q. Who gave you the referral?

16 A. I cannot recall.

17 Q. And how about Kate Kincaid? How did you find
18 Kate Kincaid?

19 A. She was referred to me by my counselor
20 EJ Millstone.

21 Q. And did you ask EJ for a referral so that you
22 would have two diagnoses that you were after to comply
23 with or meet the WPATH standards?

24 A. Yes.

25 Q. And for purposes of this lawsuit -- well, let

1 Q. Sure. As I understand, you wanted to have a
2 denial from BlueCross/BlueShield in hand for purposes of
3 this lawsuit; correct?

4 A. No.

5 Q. Why did you want to get a denial in hand from
6 BlueCross/BlueShield?

7 A. After I received the preauthorization, I wanted
8 the denial to know that I wouldn't receive a very large
9 bill after the procedure was done.

10 Q. But you haven't had the procedure; correct?

11 A. Correct.

12 Q. Did you believe having a denial from
13 BlueCross/BlueShield would help your case against your
14 employer?

15 A. Can you specify what you mean by "help"?

16 Q. Did you believe a denial from
17 BlueCross/BlueShield would advance your claims against
18 your employer?

19 A. I believed it would provide evidence for the
20 claim.

21 Q. For the claim in the lawsuit?

22 A. Yes.

23 Q. And did anyone suggest that you seek a denial
24 from BlueCross/BlueShield?

25 A. I had discussed that with my attorneys.

1 debt.

2 MS. ABDO: We very much appreciate your
3 time and patience with us today. I don't know if anyone
4 else has questions.

5 Josh, do you?

6 MR. BLOCK: Austin, do you have anything
7 further?

8 MR. YOST: No questions. Thank you for
9 your time, Dr. Toomey.

10 MR. BLOCK: I have no questions.
11 Dr. Toomey would like to read and review the transcript.

12 MS. ABDO: All right. No problem. Thank
13 you so much.

14 (4:04 p.m.)

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RUSSELL B. TOOMEY, Ph.D.

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1 STATE OF ARIZONA)
) ss.
 2 COUNTY OF MARICOPA)

3 BE IT KNOWN that the foregoing proceedings were
 4 taken before me; that the witness before testifying was
 5 duly sworn by me to testify to the whole truth; that the
 6 foregoing pages are a full, true and accurate record of
 7 the proceedings, all done to the best of my skill and
 8 ability; that the proceedings were taken down by me in
 9 shorthand and thereafter reduced to print under my
 10 direction.

11 I CERTIFY that I am in no way related to any of
 12 the parties hereto nor am I in any way interested in
 13 the outcome hereof.

14 [X] Review and signature was requested.
 15 [] Review and signature was waived/not
 16 requested.

17 I CERTIFY that I have complied with the ethical
 18 obligations set forth in ACJA 7-206(F)(3) and ACJA 7-206
 19 J(1)(g)(1) and (2). Dated at Phoenix, Arizona, this 7th
 20 of June, 2021.

21 /s/ Jennifer Hanssen

22 Jennifer Hanssen, RPR
 23 Certified Reporter
 24 Arizona CR No. 50165

* * * *

25 I CERTIFY that GRIFFIN GROUP INTERNATIONAL has
 26 complied with the ethical obligations set forth in ACJA
 27 7-206 (J)(1)(g)(1) through (6).

28 _____
 29 GRIFFIN GROUP INTERNATIONAL
 30 Registered Reporting Firm
 31 Arizona RRF No. R1005

EXHIBIT B

**Toomey vs.
State of Arizona**

**Loren Schechter
June 15, 2021**

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Russell B. Toomey,) Case No. CV19-0035-TUC-RM (LAB)
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Plaintiff,)
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vs.)
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State of Arizona, et al.,)
)
Defendants.)
_____)

VIDEOCONFERENCE DEPOSITION OF
LOREN S. SCHECHTER, M.D.

Highland Park, Illinois
June 15, 2021
11:00 a.m. CDT

REPORTED BY:
JENNIFER HANSSSEN, RPR
Certified Reporter
Certificate No. 50165

PREPARED FOR:
ASCII/CONDENSED

(Certified Copy)



1 Q. And so my question is you use the term with the
2 WPATH document, you use the term "guideline"?

3 A. Yes.

4 Q. So am I correct that the WPATH document that's
5 attached to your report is really a set of guidelines,
6 but not something that you would testify creates a
7 binding standard of care that must be followed by
8 physicians?

9 A. I would say that the document I'm now referring
10 to, the document, the Standards of Care, refers to
11 guidelines as to treatment for individuals with --
12 transgender individuals suffering from gender dysphoria,
13 gender diverse.

14 Q. Is it your opinion that the standard of care
15 that governs physicians practicing in -- let me ask you
16 this: You're licensed in Illinois; correct?

17 A. I am.

18 Q. Are you licensed in other states?

19 A. No.

20 Q. Okay. So is it your testimony that a doctor
21 licensed to practice in the state of Illinois, the
22 standard of care governing that doctor as a matter of
23 state law requires the involvement and concurrence of
24 two mental health professionals before a surgeon could
25 perform a hysterectomy with bilateral



1 salpingo-oophorectomy to alleviate gender dysphoria?

2 A. The guidelines -- these guidelines are designed
3 to be individualized, so the particulars of a treatment
4 of a particular patient would depend upon the specifics
5 involved in that case.

6 Q. And just so I'm clear -- well, let me ask you
7 this question: Is it your opinion that to comply with
8 the standard of care governing physicians in the state
9 of Illinois, that the surgeon must consult with and
10 obtain concurrence of at least one mental health
11 professional before conducting a hysterectomy with
12 bilateral salpingo-oophorectomy to alleviate gender
13 dysphoria in a transgender male?

14 A. So, again, these are guidelines that are
15 designed to be individual, depending on the particulars
16 of the case. So if there's a specific incident, a
17 specific case, I can discuss that, but other than that,
18 these are individualized guidelines.

19 Q. And I'm not sure that I got my question
20 answered. Is it your opinion that a surgeon performing
21 a hysterectomy with bilateral salpingo-oophorectomy to
22 alleviate gender dysphoria in a transgender male would
23 be required under Illinois state law to consult with and
24 obtain concurrence of a mental health professional in
25 order to comply with the legal standard of care?



1 **A. We haven't made final determinations yet, so I**
2 **can't speak to whether or not there will be changes.**

3 Q. And back to my question, I understand there's
4 not one definitive, authoritative source in this area at
5 least, but if a doctor -- a surgeon who is considering
6 performing a surgical procedure on a transgender
7 individual for gender dysphoria, are the WPATH
8 guidelines something that you would consider that person
9 could use as a reliable authority on the topic?

10 **A. Well, as I said, I don't consider any one**
11 **document as authoritative. This document is a**
12 **guideline. The guidelines are individualized and**
13 **flexible and apply to the circumstances of the**
14 **individual person.**

15 Q. Doctor, I wanted to close the loop before we
16 went on about your billings, which are Exhibit 2. I
17 think we have concluded that when you say in the work
18 "review of draft," that that mostly was preparing the
19 report in this case, and that your best estimate was
20 around 30 minutes of your total time was spent reviewing
21 the Arizona plan.

22 Was there anything besides those two items
23 of work, preparing the report and reviewing the Arizona
24 plan, that would be included with "review of draft"?

25 **A. That would be editing and reviewing the draft,**



1 though, that Dr. Toomey is seeking the hysterectomy,
2 bilateral salpingo-oophorectomy for the treatment of
3 gender dysphoria?

4 **A. I'm just going to look at the Amended Complaint**
5 **again before I answer. Yes, it is.**

6 Q. And so the deferral, the voluntary deferral
7 under my hypothetical of this treatment for gender
8 dysphoria, regardless of how long that deferral is, if
9 it was even just for the sole purpose of being a
10 plaintiff in this lawsuit does not affect your opinion
11 as to whether or not it is medically necessary?

12 MR. BLOCK: Objection.

13 **A. That is correct.**

14 Q. BY MR. NORTHUP: Now, I know you haven't spoken
15 with Dr. Toomey. My understanding is it's never been,
16 as far as you know, the intention that if Dr. Toomey has
17 the hysterectomy, bilateral salpingo-oophorectomy, that
18 you would be the surgeon doing it; is that right?

19 **A. Correct.**

20 Q. Do you actually, Doctor, perform
21 hysterectomies, bilateral salpingo-oophorectomy?

22 **A. Under an IRB protocol, in which I participate,**
23 **I am involved in the provision of surgical services for**
24 **hysterectomy and salpingo-oophorectomy.**

25 Q. And what role -- you say an IRP protocol?



1 A. IRB, as in boy, Institutional Review Board.

2 Q. And what is IRB, Institutional Review Board?

3 A. We have a -- I have a research interest in
4 uterine transplantation.

5 Q. And so what role under that IRB protocol do you
6 play as part of your involvement with the provision of
7 services with a hysterectomy or an oophorectomy?

8 A. Procuring the donor uterus and implanting the
9 donor uterus.

10 Q. Have you ever done -- been involved in that
11 procuring and implanting the donor uterus in a
12 transsexual --

13 A. Well, I assume you mean transgender.

14 Q. Transgender, I'm sorry. Transgender.

15 A. That is the purpose of our IRB.

16 Q. Is the purpose that that procedure would be
17 done on a transgender female?

18 A. Ultimately, that the uterine procurement, the
19 donation, would be from a transgender man, and the
20 recipient would be a transgender woman.

21 Q. Is it always from, the donor, a transgender
22 man?

23 A. Is what?

24 Q. In other words, is the donor, in your
25 experience, always a transgender man as opposed to a



1 cisgender woman?

2 A. No, the uterine procurement may be from
3 altruistic donors. Those may be cisgender women who are
4 voluntarily donating the uterus. It may be performed
5 from heart beating, brain deceased, cisgender
6 individuals, and it may be performed from a transgender
7 man seeking hysterectomy and/or salpingo-oophorectomy.

8 Q. And I take it the purpose of that surgery is
9 to -- is it to try to impart fertility on the recipient
10 or is it simply just to give them the organs that a
11 cisgender woman would have been born with?

12 A. Ultimately, the goal would be to experience
13 live birth.

14 Q. Is the technology -- has that ever happened?

15 A. It has happened in cisgender women with the
16 condition of absolute uterine infertility. Our plan is
17 to perform the procedure for transgender women.

18 Q. And so back to, I guess, my original question,
19 other than the involvement of procuring and implanting a
20 uterus under the IRB protocol, does your practice
21 involve performing hysterectomies or
22 salpingo-oophorectomies?

23 A. I assist in the procedure. So, for example, as
24 of last week or the week before, I'll work with our
25 gynecologist, who is the primary surgeon, and then I



1 will assist in that procedure. I'm not the primary
2 surgeon, however, for that procedure.

3 Q. Right. And when you're talking about assisting
4 and not being the primary surgeon, that is in the
5 provision and implantation of a donor uterus under the
6 IRB protocol?

7 A. No, no, now I'm not discussing the research
8 protocol. For the provision of clinical services for
9 transgender men, I will assist the gynecologist
10 performing the hysterectomy, although I am not the
11 primary surgeon for that.

12 Q. And in a situation -- you understand
13 Dr. Toomey, the procedure that he wants to have, which
14 is the hysterectomy, bilateral salpingo-oophorectomy,
15 would there be a reason in that surgery for a plastic
16 surgeon such as yourself to be involved or would it just
17 be a gynecologist?

18 A. It would typically be a gynecologist unless an
19 additional procedure on the genitalia was also -- was
20 performed concurrently.

21 Q. So if it was just the hysterectomy with
22 bilateral salpingo-oophorectomy, normally, you wouldn't
23 expect to have a plastic surgeon there?

24 A. I would not typically be involved in that case.

25 Q. And is it your understanding that Dr. Toomey



1 follow-up questions that counsel might ask you, that's
2 all I have.

3 **A. Thank you.**

4 MR. NORTHUP: Are we done?

5 (Discussion off the record.)

6 MS. COHAN: Austin, do you have any
7 questions for Dr. Schechter?

8 MR. YOST: I do not have any questions.

9 (Discussion off the record.)

10 MR. NORTHUP: Okay. So looks like no
11 questions. He said you'll read and sign. Doctor, I
12 appreciate your time.

13 **A. Thank you very much. Appreciate it.**

14 (3:40 p.m.)

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LOREN SCHECHTER, M.D.

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Toomey vs.
State of Arizona

Loren Schechter
June 15, 2021

1 STATE OF ARIZONA)
) ss.
2 COUNTY OF MARICOPA)

3 BE IT KNOWN that the foregoing proceedings were
4 taken before me; that the witness before testifying was
5 duly sworn by me to testify to the whole truth; that the
6 foregoing pages are a full, true and accurate record of
7 the proceedings, all done to the best of my skill and
8 ability; that the proceedings were taken down by me in
9 shorthand and thereafter reduced to print under my
10 direction.

11 I CERTIFY that I am in no way related to any of
12 the parties hereto nor am I in any way interested in
13 the outcome hereof.

14 [X] Review and signature was requested.
15 [] Review and signature was waived/not
16 requested.

17 I CERTIFY that I have complied with the ethical
18 obligations set forth in ACJA 7-206(F)(3) and ACJA 7-206
19 J(1)(g)(1) and (2). Dated at Phoenix, Arizona, this 28th
20 of June, 2021.

21 /s/ Jennifer Hanssen
22 Jennifer Hanssen, RPR
23 Certified Reporter
24 Arizona CR No. 50165

25 * * * *

26 I CERTIFY that GRIFFIN GROUP INTERNATIONAL has
27 complied with the ethical obligations set forth in ACJA
28 7-206 (J)(1)(g)(1) through (6).

29 /s/ Pamela A. Griffin
30 _____
31 GRIFFIN GROUP INTERNATIONAL
32 Registered Reporting Firm
33 Arizona RRF No. R1005



EXHIBIT B

**Toomey vs.
State of Arizona**

**Loren Schechter
June 15, 2021**

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Russell B. Toomey,) Case No. CV19-0035-TUC-RM (LAB)
)
Plaintiff,)
)
vs.)
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State of Arizona, et al.,)
)
Defendants.)
_____)

VIDEOCONFERENCE DEPOSITION OF
LOREN S. SCHECHTER, M.D.

Highland Park, Illinois
June 15, 2021
11:00 a.m. CDT

REPORTED BY:
JENNIFER HANSSEN, RPR
Certified Reporter
Certificate No. 50165

PREPARED FOR:
ASCII/CONDENSED

(Certified Copy)



1 Q. And so my question is you use the term with the
2 WPATH document, you use the term "guideline"?

3 A. Yes.

4 Q. So am I correct that the WPATH document that's
5 attached to your report is really a set of guidelines,
6 but not something that you would testify creates a
7 binding standard of care that must be followed by
8 physicians?

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10 to, the document, the Standards of Care, refers to
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20 Q. Okay. So is it your testimony that a doctor
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22 standard of care governing that doctor as a matter of
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24 two mental health professionals before a surgeon could
25 perform a hysterectomy with bilateral



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4 of a particular patient would depend upon the specifics
5 involved in that case.

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9 of Illinois, that the surgeon must consult with and
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21 a hysterectomy with bilateral salpingo-oophorectomy to
22 alleviate gender dysphoria in a transgender male would
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24 obtain concurrence of a mental health professional in
25 order to comply with the legal standard of care?



1 **A. We haven't made final determinations yet, so I**
2 **can't speak to whether or not there will be changes.**

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4 not one definitive, authoritative source in this area at
5 least, but if a doctor -- a surgeon who is considering
6 performing a surgical procedure on a transgender
7 individual for gender dysphoria, are the WPATH
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13 **flexible and apply to the circumstances of the**
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16 went on about your billings, which are Exhibit 2. I
17 think we have concluded that when you say in the work
18 "review of draft," that that mostly was preparing the
19 report in this case, and that your best estimate was
20 around 30 minutes of your total time was spent reviewing
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4 **A. I'm just going to look at the Amended Complaint**
5 **again before I answer. Yes, it is.**

6 Q. And so the deferral, the voluntary deferral
7 under my hypothetical of this treatment for gender
8 dysphoria, regardless of how long that deferral is, if
9 it was even just for the sole purpose of being a
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11 as to whether or not it is medically necessary?

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21 hysterectomies, bilateral salpingo-oophorectomy?

22 **A. Under an IRB protocol, in which I participate,**
23 **I am involved in the provision of surgical services for**
24 **hysterectomy and salpingo-oophorectomy.**

25 Q. And what role -- you say an IRP protocol?



1 A. IRB, as in boy, Institutional Review Board.

2 Q. And what is IRB, Institutional Review Board?

3 A. We have a -- I have a research interest in
4 uterine transplantation.

5 Q. And so what role under that IRB protocol do you
6 play as part of your involvement with the provision of
7 services with a hysterectomy or an oophorectomy?

8 A. Procuring the donor uterus and implanting the
9 donor uterus.

10 Q. Have you ever done -- been involved in that
11 procuring and implanting the donor uterus in a
12 transsexual --

13 A. Well, I assume you mean transgender.

14 Q. Transgender, I'm sorry. Transgender.

15 A. That is the purpose of our IRB.

16 Q. Is the purpose that that procedure would be
17 done on a transgender female?

18 A. Ultimately, that the uterine procurement, the
19 donation, would be from a transgender man, and the
20 recipient would be a transgender woman.

21 Q. Is it always from, the donor, a transgender
22 man?

23 A. Is what?

24 Q. In other words, is the donor, in your
25 experience, always a transgender man as opposed to a



1 cisgender woman?

2 A. No, the uterine procurement may be from
3 altruistic donors. Those may be cisgender women who are
4 voluntarily donating the uterus. It may be performed
5 from heart beating, brain deceased, cisgender
6 individuals, and it may be performed from a transgender
7 man seeking hysterectomy and/or salpingo-oophorectomy.

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9 to -- is it to try to impart fertility on the recipient
10 or is it simply just to give them the organs that a
11 cisgender woman would have been born with?

12 A. Ultimately, the goal would be to experience
13 live birth.

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15 A. It has happened in cisgender women with the
16 condition of absolute uterine infertility. Our plan is
17 to perform the procedure for transgender women.

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20 uterus under the IRB protocol, does your practice
21 involve performing hysterectomies or
22 salpingo-oophorectomies?

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24 of last week or the week before, I'll work with our
25 gynecologist, who is the primary surgeon, and then I



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4 and not being the primary surgeon, that is in the
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7 A. No, no, now I'm not discussing the research
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19 additional procedure on the genitalia was also -- was
20 performed concurrently.

21 Q. So if it was just the hysterectomy with
22 bilateral salpingo-oophorectomy, normally, you wouldn't
23 expect to have a plastic surgeon there?

24 A. I would not typically be involved in that case.

25 Q. And is it your understanding that Dr. Toomey



1 follow-up questions that counsel might ask you, that's
2 all I have.

3 **A. Thank you.**

4 MR. NORTHUP: Are we done?

5 (Discussion off the record.)

6 MS. COHAN: Austin, do you have any
7 questions for Dr. Schechter?

8 MR. YOST: I do not have any questions.

9 (Discussion off the record.)

10 MR. NORTHUP: Okay. So looks like no
11 questions. He said you'll read and sign. Doctor, I
12 appreciate your time.

13 **A. Thank you very much. Appreciate it.**

14 (3:40 p.m.)

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LOREN SCHECHTER, M.D.

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Toomey vs.
State of Arizona

Loren Schechter
June 15, 2021

1 STATE OF ARIZONA)
) ss.
2 COUNTY OF MARICOPA)

3 BE IT KNOWN that the foregoing proceedings were
4 taken before me; that the witness before testifying was
5 duly sworn by me to testify to the whole truth; that the
6 foregoing pages are a full, true and accurate record of
7 the proceedings, all done to the best of my skill and
8 ability; that the proceedings were taken down by me in
9 shorthand and thereafter reduced to print under my
10 direction.

11 I CERTIFY that I am in no way related to any of
12 the parties hereto nor am I in any way interested in
13 the outcome hereof.

14 [X] Review and signature was requested.
15 [] Review and signature was waived/not
16 requested.

17 I CERTIFY that I have complied with the ethical
18 obligations set forth in ACJA 7-206(F)(3) and ACJA 7-206
19 J(1)(g)(1) and (2). Dated at Phoenix, Arizona, this 28th
20 of June, 2021.

21 /s/ Jennifer Hanssen
22 Jennifer Hanssen, RPR
23 Certified Reporter
24 Arizona CR No. 50165

25 * * * *

26 I CERTIFY that GRIFFIN GROUP INTERNATIONAL has
27 complied with the ethical obligations set forth in ACJA
28 7-206 (J)(1)(g)(1) through (6).

29 /s/ Pamela A. Griffin
30 _____
31 GRIFFIN GROUP INTERNATIONAL
32 Registered Reporting Firm
33 Arizona RRF No. R1005



**Exhibit C
LODGED
UNDER SEAL**

Exhibit D
LODGED
UNDER SEAL

EXHIBIT E



Medical Coverage Policy

Effective Date 4/15/2019
 Next Review Date..... 3/15/2020
 Coverage Policy Number 0266

Treatment of Gender Dysphoria

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Related Coverage Resources

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- [Breast Reconstruction Following Mastectomy or Lumpectomy](#)
- [Dermabrasion and Chemical Peels](#)
- [Endometrial Ablation](#)
- [Infertility Services](#)
- [Male Sexual Dysfunction Treatment: Non-pharmacologic](#)
- [Panniculectomy and Abdominoplasty](#)
- [Preventive Care Services](#)
- [Reduction Mammoplasty](#)
- [Rhinoplasty, Vestibular Stenosis Repair, and Septoplasty](#)
- [Redundant Skin Surgery](#)
- [Speech Therapy](#)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses treatment of gender dysphoria. Gender dysphoria is defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and the person's assigned sex at birth (World Professional Association for Transgender Health, [WPATH], 2012).

Coverage Policy

Coverage for treatment of gender dysphoria varies across plans. Refer to the customer's benefit plan document for coverage details. Coverage for treatment of gender dysphoria, including gender reassignment surgery and related may be governed by state and/or federal mandates.

Unless otherwise specified in a benefit plan, the following conditions of coverage apply for treatment of gender dysphoria and/or gender reassignment surgery and related procedures, including all applicable benefit limitations, precertification, or other medical necessity criteria.

SERVICES MEDICALLY NECESSARY

Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:

- Behavioral health services, including but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression)
- Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues, estrogens, and progestins.
- Laboratory testing to monitor prescribed hormonal therapy
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individuals biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition)
- Gender reassignment and related surgery (see below).

Gender Reassignment Surgery

Gender reassignment surgery (see Table 1) is considered medically necessary treatment of gender dysphoria when the individual is age 18 years or older and when the following criteria are met:

- **For initial mastectomy:** one letter of support from a qualified mental health professional

NOTE: The Women's Health and Cancer Rights Act (WHCRA), 29 U.S. Code § 1185b requires coverage of certain post-mastectomy services related to breast reconstruction and treatment of physical complications from mastectomy including nipple-areola reconstruction.

- **For hysterectomy, salpingo-oophorectomy, orchiectomy:**
 - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
 - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required.
- **For reconstructive genital surgery:**
 - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
 - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required AND
 - documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity.

Table 1: Gender Reassignment Surgery

Procedure	CPT / HCPCS codes (This list may not be all inclusive)
Initial mastectomy*, nipple-areola reconstruction (related to mastectomy or post mastectomy reconstruction)	19303, 19304, 19350
Hysterectomy and salpingo-oophorectomy	58150, 58260 58262 58291, 58552, 58554,

	58571, 58573, 58661
Female to male reconstructive genital surgery which may include any of the following:	55980
Vaginectomy**/colpectomy	57110
Vulvectomy	56625
Metoidioplasty	58999
Phalloplasty	58999
Electrolysis of donor site tissue to be used for phalloplasty	17380
Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir	54400, 54401, 54405, C1813, C2622
Urethroplasty /urethromeatoplasty	53430, 53450
Orchiectomy	54520, 54690
Male to female reconstructive genital surgery, which may include any of the following:	55970
Vaginoplasty**, (e.g, construction of vagina with/without graft, colovaginoplasty)	57291, 57292, 57335
Electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty	17380
Penectomy	54125
Vulvoplasty, (e.g., labiaplasty, clitoroplasty, penile skin inversion)	56620, 56805
Repair of introitus	56800
Coloproctostomy	44145, 55899

***Note:** Please reference the Cigna Medical Coverage Policy 0152 Reduction Mammoplasty for conditions of coverage related to breast reduction.

****Note:** For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment therapy is required. An additional 12 months of hormone therapy is not required for vaginectomy or vaginoplasty procedures.

NOT MEDICALLY NECESSARY SERVICES

Gender reassignment surgery is considered not medically necessary when the applicable medical necessity criteria for the procedure(s) has not been met.

Each of the following is excluded under many benefit plans and/or considered not medically necessary as part of gender reassignment for preservation of fertility (see Table 2):

Table: 2 Excluded and/or Not Medically Necessary- Fertility Preservation

Procedure	CPT/HCPCS Code
Cryopreservation of embryo, sperm, oocytes	89258, 89259, 89337
Procurement of embryo, sperm, oocytes	S4030, S4031
Storage of embryo, sperm, oocytes	89342, 89343, 89346, S4027, S4040

EXPERIMENTAL /INVESTIGATIONAL/UNPROVEN SERVICES

Each of the following is considered experimental, investigational or unproven as part of gender reassignment for the preservation of fertility (see Table 3):

Table: 3 Experimental, Investigational or Unproven - Fertility Preservation

Procedure	CPT/HCPCS Code
Cryopreservation of immature oocytes	0357T
Cryopreservation of reproductive tissue (i.e., ovaries, testicular tissue)	89335, 0058T
Storage of reproductive tissue (i.e., ovaries, testicular tissue)	89344
Thawing of reproductive tissue (i.e., ovaries, testicular tissue)	89354

COSMETIC SERVICES

Each of the following services (see Table 4) is considered cosmetic and/or not medically necessary for the purpose of improving or altering appearance or self-esteem related to one's appearance, including gender specific appearance for an individual with gender dysphoria:

Table 4: Cosmetic and/or Not Medically Necessary (Unless coverage is specifically listed as available in the applicable benefit plan document)

Facial Feminization/Masculinization Procedures	CPT/HCPCS Code
Blepharoplasty	15820, 15821, 15822, 15823
Cheek/malar implants	17999
Chin/nose implants	21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450
Collagen injections	11950, 11951, 11952, 11954
Face/forehead lift	15824, 15825, 15826, 15828, 15829, 21137
Facial bone reduction (osteoplasty)	21209
Hair removal/hair transplantation	15775, 15776, 17380
Jaw reduction	21120, 21121, 21122, 21223, 21125, 21127
Laryngoplasty	31599
Rhinoplasty	21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450
Skin resurfacing (e.g., dermabrasion, chemical peels)	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Thyroid reduction chondroplasty	31750
Neck tightening	15825

Chest Reconstruction Procedures	CPT/HCPCS Code
Breast augmentation with implants	19324, 19325, 19340, 19342, C1789
Mastopexy	19316
Nipple/areola reconstruction (unrelated to mastectomy or post mastectomy reconstruction)	19350
Pectoral Implants	L8600, 17999

Voice Modification Therapy/Procedures	CPT/HCPCS Code
Voice modification surgery	31599, 31899
Voice therapy/voice lessons	92507

Other Miscellaneous Procedures	CPT/HCPCS Code
Abdominoplasty	15847

Calf implants	17999
Electrolysis, other than when performed pre-vaginoplasty as outlined above	17380
Insertion of testicular prosthesis	54660
Removal of redundant skin	15830, 15832, 15833, 15834, 15835, 15836 15837, 15838, 15839
Replacement of tissue expander with permanent prosthesis testicular insertion	11970
Scrotoplasty	55175, 55180
Suction assisted lipoplasty, lipofilling, and/or liposuction	15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879
Testicular expanders, including replacement with prosthesis, testicular prosthesis	11960, 11970, 11971, 54660

General Background

The causes of gender dysphoria and the developmental factors associated with them are not well-understood. Treatment of individuals with gender dysphoria varies, with some treatments involving a change in gender expression or body modifications. The term “transsexual” refers to an individual whose gender identity is not congruent with their genetic and/or assigned sex and usually seeks hormone replacement therapy (HRT) and possibly gender-affirmation surgery to feminize or masculinize the body and who may live full-time in the crossgender role. Transsexualism is a form of gender dysphoria. Other differential diagnoses include, but are not limited to, partial or temporary disorders as seen in adolescent crisis, transvestitism, refusal to accept a homosexual orientation, psychotic misjudgments of gender identity and severe personality disorders (Becker, et al., 1998). Individuals that are transsexual, transgender, or gender nonconforming (i.e., gender identity differs from the cultural norm) may experience gender dysphoria.

Treatment of gender dysphoria is unique to each individual and may or may not involve body modifications. Some individuals require only psychotherapy, some require a change in gender roles/expression, and others require hormone therapy and/or surgery to facilitate a gender transition.

Behavioral Health Services

Licensing requirements and scope of practice vary by state for healthcare professionals. WPATH has defined recommended minimum credentials for a mental health professional to be qualified to evaluate or treat adult individuals with gender dysphoria. In addition to general licensing requirements, WPATH includes a minimum of a Master’s or more advanced degree from an accredited institution, an ability to recognize and diagnose coexisting mental health concerns, and an ability to distinguish such conditions from gender dysphoria. Mental health professionals play a strong role in working with individuals with gender dysphoria as they need to diagnose the gender disorder and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, and provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. For children and adolescents, the mental health professional should also be trained in child and adolescent developmental psychopathology.

Once the individual is evaluated, the mental health professional provides documentation and formal recommendations to medical and surgical specialists. Documentation for hormonal and/or surgery should be comprehensive and include the extent to which eligibility criteria have been met (i.e., confirmed gender dysphoria, capacity to make a fully informed decision, age \geq 18 years or age of majority, and other significant medical or behavioral health concerns are well-controlled), in addition to the following:

- individual’s general identifying characteristics
- the initial and evolving gender, sexual and psychiatric diagnoses
- details regarding the type and duration of psychotherapy or evaluation the individual received
- the mental health professional’s rationale for hormone therapy or surgery
- the degree to which the individual has followed the standards of care and likelihood of continued compliance

- whether or not the mental health professional is a part of a gender team

For breast surgery WPATH Standards of Care Version 7 require one referral from a qualified mental health professional, as defined above. For genital surgery WPATH requires two referrals from qualified mental health professionals indicating criteria for surgery has been met. In contrast, the Endocrine Society Clinical Practice Guidelines (Hembree, et al., 2009) recommend both an endocrinologist responsible for endocrine transition therapy and a mental health professional certify the individual is eligible and meets WPATH criteria for gender reassignment surgery.

Psychiatric care may need to continue for several years after gender reassignment surgery, as major psychological adjustments may continue to be necessary. Other providers of care may include a family physician or internist, endocrinologist, urologist, plastic surgeon, general surgeon and gynecologist. The overall success of the surgery is highly dependent on psychological adjustment and continued support.

After diagnosis, the therapeutic approach is individualized but generally includes three elements: sex hormone therapy of the identified gender, real life experience in the desired role, and surgery to change the genitalia and other sex characteristics.

Hormonal Therapy

For both adults and adolescents, hormonal treatment for gender dysphoria must be administered and monitored by a qualified healthcare practitioner as therapy requires ongoing medical management, including physical examination and laboratory evaluation studies to manage dosage, side effects, etc. Lifelong maintenance is usually required.

Adults: Prior to and following gender reassignment surgery, individuals undergo hormone replacement therapy, unless medically contraindicated. Biological males are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Biological females are treated with androgens such as testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes hormone replacement therapy (HRT) may be effective in reducing the adverse psychologic impact of gender dysphoria. Hormone therapy is usually initiated upon referral from a qualified mental health professional or a health professional competent in behavioral health and gender dysphoria treatment specifically. Twelve months of continuous hormone therapy (gender appropriate) is required prior to hysterectomy and salpingo-oophorectomy and orchiectomy.

Adolescents: Puberty-suppressing hormones (e.g., GnRH analogues) for adolescents may be provided to individuals who have reached at least Tanner stage 2 of sexual development. The Endocrine Society supports puberty suppression and has developed criteria for a subset of individuals who fulfill and meet eligibility readiness for gender reassignment (Hembree, et al., 2009). WPATH clinical recommendations also support puberty suppression (WPATH, 2012) for a similar subset of individuals. Consistent with adult hormone therapy, treatment of adolescents involves a multidisciplinary team, however when treating an adolescent a pediatric endocrinologist should be included as a part of the team. Pre-pubertal hormone suppression differs from hormone therapy used in adults and may not be without consequence; some pharmaceutical agents may cause negative physical side effects (e.g., height, bone growth).

Gender Reassignment Surgery

The term "gender reassignment surgery," also known as sexual reassignment surgery, gender confirming surgery or gender affirmation surgery, may be part of a treatment plan for gender dysphoria. The terms may be used to refer to either the reconstruction of male or female genitalia specifically, or the reshaping by any surgical procedure of a male body into a body with female appearance, or vice versa.

Gender identity disorder does not persist into adolescence in most children (Hembree, et al., 2009). Evidence suggests that 75-80% of prepubertal children do not turn out to be transsexual in adolescence (Hembree, et al., 2009). According to WPATH (2007) persistence of gender dysphoria from adolescence into adulthood is much higher. Performing gender reassignment surgery prior to age 18, or the legal age to give consent, is not recommended by professional societies (American College of Obstetricians and Gynecology [ACOG], 2017;

WPATH, 2012; American Psychiatric Association (APA), 2012, Endocrine Society, 2009). Gender reassignment surgery is intended to be a permanent change (non-reversible), establishing congruency between an individual's gender identity and physical appearance. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine and urological examination, and a clinical psychiatric/psychological examination. Individuals who choose to undergo gender reassignment surgery must be fully informed regarding treatment options with confirmation from the mental health professional that the individual is considered a candidate for surgical treatment.

Twelve months of continuous hormone therapy is required prior to irreversible genital surgery. In addition, prior to surgery the individual identified with gender dysphoria must undergo a "real life experience," in which he/she adopts the new or evolving gender role and lives in that role for at least 12 continuous months as part of the transition pathway. This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During this time, a person would be expected to maintain their baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Other Associated Surgical Procedures

Services Otherwise Medically Necessary: Age appropriate gender-specific services that would otherwise be considered medically necessary remain medically necessary services for transgender individuals, as appropriate to their biological anatomy. Examples include (but are not limited to):

- for female to male transgender individuals who have not undergone a mastectomy, breast cancer and cervical cancer screening
- for male to female transgender individuals who have retained their prostate cancer screening or treatment of a prostate condition.

Reversal of Gender Reassignment: Gender reassignment surgery is considered an irreversible intervention (WPATH, 2012). Although infrequent, surgery to reverse a partially or fully completed gender reassignment (reversal of surgery to revise secondary sex characteristics), may be necessary as a result of a complication (i.e., infection) or other medical condition necessitating surgical intervention.

Fertility Preservation: Both hormone therapy and gender reassignment surgery limits fertility, and individuals should be informed of sperm preservation options and other cryopreservation services prior to starting hormone therapy. Reproductive options should also be discussed prior to surgery for individuals who are of child-bearing age. However, procedures aimed at preservation of fertility (e.g., procurement, cryopreservation, and storage of sperm, oocytes and/or embryos) performed prior to gender reassignment surgery are considered not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Cosmetic Procedures: Various other surgical procedures may be performed as part of gender reassignment surgery. Although WPATH does not define medical necessity criteria for masculinization and feminization procedures, referral by a qualified mental health professional is recommended. When performed as part of gender reassignment surgery such procedures, aimed primarily at improving personal appearance (i.e., masculinization, feminization), are performed to assist with improving culturally appropriate male or female appearance characteristics and are therefore considered cosmetic and are not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Professional Society/Organization

American College of Obstetricians and Gynecologists (ACOG): ACOG published a Committee Opinion in 2017 for the care of transgender adolescents. Within this document regarding surgical management ACOG notes transgender male patients may undergo phalloplasty when one reaches the age of majority, and a transgender female patient may undergo vaginoplasty when one reaches the age of majority. In addition the authors acknowledge the Endocrine Society guidelines (Hembree, et al., 2009) which state that an individual is at least age 18 years for genital reconstructive surgery (ACOG, 2017).

American Psychiatric Association (APA): In 2012 the APA published a task force report on treatment of gender identity disorder. Within this document, regarding adolescents specifically, the authors state the evidence is inadequate to develop a guideline regarding the timing of sex reassignment surgery. However the task force acknowledges the Endocrine Society guidelines (Hembree, et al., 2009) and that given the irreversible nature of surgery, for adolescents most clinicians advise waiting until the individual has attained the age of legal consent and a degree of independence (APA, 2012).

WPATH Standards of Care: The World Professional Association for Transgender Health (WPATH) promotes standards of health care for individuals through the articulation of “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People” (WPATH, 2012, Version 7). WPATH standards of care are based on scientific evidence and expert consensus and are commonly utilized as clinical recommendations for individuals seeking treatment of gender disorders.

Endocrine Society: In 2009 the Endocrine Society published a clinical practice guideline for endocrine treatment of transsexual persons (Hembree, et al., 2009). As part of this guideline, the endocrine society recommends that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery advisable; that surgery be recommended only after completion of at least one year of consistent and compliant hormone treatment; and that the physician responsible for endocrine treatment medically clear the individual for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery.

Centers for Medicare & Medicaid Services (CMS)

- National Coverage Determination (NCD): No NCD found.
- Local Coverage Determination (LCD): No LCD found.

Use Outside of the US: Several other countries including the United Kingdom offer treatment options for individuals with gender dysphoria. Treatments are similar to those offered in the United States.

Coding/Billing Information

- Note:** 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Intersex Surgery: Male to Female

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55970†	Intersex surgery; male to female
	†Includes only the following procedures:
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55899††	Unlisted procedure, male genital system
56620	Vulvectomy simple; partial
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state

††Note: Considered medically necessary when used to report Coloproctostomy.

Intersex Surgery: Female to Male

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55980†	Intersex surgery, female to male
	†Includes only the following procedures:
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19350††	Nipple/areola reconstruction
53430	Urethroplasty, reconstruction of female urethra
53450	Urethromeatoplasty, with mucosal advancement
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
56625	Vulvectomy simple; complete
57110	Vaginectomy, complete removal of vaginal wall
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58999†††	Unlisted procedure, female genital system (nonobstetrical)

††Note: Considered medically necessary when performed as part of a mastectomy or breast reconstruction procedure following a mastectomy.

†††Note: Considered medically necessary when used to report metoidioplasty with phalloplasty.

HCPCS Codes	Description
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable

ICD-10-CM Diagnosis Codes	Description
F64.0	Trans-sexualism

F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Generally Excluded/Not Medically Necessary:

CPT®* Codes	Description
89258	Cryopreservation; embryo(s)
89259	Cryopreservation; sperm
89337	Cryopreservation, mature oocyte(s)
89342	Storage (per year); embryo(s)
89343	Storage (per year); sperm/semens
89346	Storage (per year); oocyte(s)

HCPCS Codes	Description
S4027	Storage of previously frozen embryos
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit
S4040	Monitoring and storage of cryopreserved embryos, per 30 days

Considered Experimental/Investigational/Unproven:

CPT®* Codes	Description
89335	Cryopreservation, reproductive tissue, testicular
89344	Storage (per year); reproductive tissue, testicular/ovarian
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
0058T	Cryopreservation; reproductive tissue, ovarian
0357T	Cryopreservation; immature oocyte(s)

Considered Cosmetic and/or not medically necessary when performed as a component of gender reassignment, even when coverage for gender reassignment surgery exists unless subject to a coverage mandate:

CPT®* Codes	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary)

	procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy, forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999†	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350††	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599†††	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
31899††††	Unlisted procedure, trachea, bronchi
40799†††††	Unlisted procedure, lips
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

HCPCS Codes	Description
C1789	Prosthesis, breast (implantable)
L8600	Implantable breast prosthesis, silicone or equal

†Note: Cosmetic and/or not medically necessary when used to report calf, cheek, malar or pectoral implants or fat transfers performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

††Note: Cosmetic and/or not medically necessary when not performed as part of a mastectomy or breast reconstructive procedure.

†††Note: Cosmetic and/or not medically necessary when used to report laryngoplasty performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

††††Note: Cosmetic and/or not medically necessary when used to report voice modification surgery performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

†††††Note: Cosmetic and/or not medically necessary when used to report lip reduction/enhancement performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

***Current Procedural Terminology (CPT®) ©2018 American Medical Association: Chicago, IL.**

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EXHIBIT F

GENDER DYSPHORIA TREATMENT

Policy Number: CS145.F

Effective Date: January 1, 2020

[Instructions for Use](#) ⓘ

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Related Community Plan Policies

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- [Botulinum Toxins A and B](#)
- [Cosmetic and Reconstructive Procedures](#)
- [Gonadotropin Releasing Hormone Analogs](#)
- [Panniculectomy and Body Contouring Procedures](#)
- [Rhinoplasty and Other Nasal Surgeries](#)
- [Speech Language Pathology Services](#)

Commercial Policy

- [Gender Dysphoria Treatment](#)

APPLICATION

This policy does not apply to the state of Tennessee.

COVERAGE RATIONALE

See [Benefit Considerations](#) ⓘ

Note: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development.

Gender reassignment surgery may be indicated for individuals who provide the following documentation:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating [Gender Dysphoria](#) is needed for breast surgery. The assessment must document that an individual meets **all** of the following criteria:
 - Persistent, well-documented Gender Dysphoria
 - Capacity to make a fully informed decision and to consent for treatment
 - Must be at least 18 years of age (age of majority)
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
- A written psychological assessment from at least two qualified behavioral health providers experienced in treating [Gender Dysphoria](#), who have independently assessed the individual, are required for genital surgery. The assessment must document that an individual meets **all** of the following criteria:
 - Persistent, well-documented Gender Dysphoria
 - Capacity to make a fully informed decision and to consent for treatment
 - Must be at least 18 years of age (age of majority)
 - If significant medical or mental health concerns are present, they must be reasonably well controlled
 - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender
 - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated)
- Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating Gender Dysphoria.

*See the Optum Coverage Determination Guideline titled *Gender Dysphoria* for provider qualification criteria (to access this guideline, go to: [Optum Provider Express > Clinical Resources > Guidelines/Policies/Manuals > Coverage Determination Guidelines](#)).

When the above criteria are met, the following gender reassignment surgical procedures are medically necessary and covered as a proven benefit:

- **Male-to-Female (MtF):**
 - Clitoroplasty (creation of clitoris)
 - Labiaplasty (creation of labia)
 - Orchiectomy (removal of testicles)
 - Penectomy (removal of penis)
 - Urethroplasty (reconstruction of female urethra)
 - Vaginoplasty (creation of vagina)
 - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of gender dysphoria
- **Female-to-Male (FtM):**
 - Bilateral mastectomy or breast reduction*
 - Hysterectomy (removal of uterus)
 - Metoidioplasty (creation of penis, using clitoris)
 - Penile prosthesis
 - Phalloplasty (creation of penis)
 - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
 - Scrotoplasty (creation of scrotum)
 - Testicular prostheses
 - Urethroplasty (reconstruction of male urethra)
 - Vaginectomy (removal of vagina)
 - Vulvectomy (removal of vulva)
 - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of gender dysphoria

*Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure.

Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary when performed as part of gender reassignment:

- Abdominoplasty (also see the Coverage Determination Guideline titled [Panniculectomy and Body Contouring Procedures](#))
- Blepharoplasty (also see the Coverage Determination Guideline titled [Blepharoplasty, Blepharoptosis and Brow Ptosis Repair](#))
- Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also see the Coverage Determination Guideline titled [Panniculectomy and Body Contouring Procedures](#))
- Breast enlargement, including augmentation mammoplasty and breast implants
- Brow lift
- Calf implants
- Cheek, chin and nose implants
- Face/forehead lift and/or neck tightening
- Facial bone remodeling for facial feminization
- Hair transplantation
- Injection of fillers or neurotoxins (also see the Medical Benefit Drug Policy titled [Botulinum Toxins A and B](#))
- Laser or electrolysis hair removal not related to genital reconstruction
- Lip augmentation
- Lip reduction
- Liposuction (suction-assisted lipectomy) (also see the Coverage Determination Guideline titled [Panniculectomy and Body Contouring Procedures](#))
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty (also see the Coverage Determination Guideline titled [Rhinoplasty and Other Nasal Surgeries](#))
- Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
- Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
- Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords)
- Voice lessons and voice therapy

DEFINITIONS

Gender Dysphoria in Adolescents and Adults: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least two** of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
- B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender Dysphoria in Children: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least six** of the following (**one of which must be criterion A1**):
1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
 3. A strong preference for cross-gender roles in make-believe play or fantasy play
 4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
 5. A strong preference for playmates of the other gender
 6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities
 7. A strong dislike of one's sexual anatomy
 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender
- B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

CPT Code	Description
15750	Flap; neurovascular pedicle
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

CPT Code	Description
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Reduction mammoplasty
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
21899	Unlisted procedure, neck or thorax
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair

CPT Code	Description
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

CPT Code	Description
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

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ICD-10 Diagnosis Code	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

DESCRIPTION OF SERVICES

Gender Dysphoria is a condition in which there is a marked incongruence between an individual's experienced/expressed gender and assigned gender (DSM-5). Treatment options include behavioral therapy, psychotherapy, hormone therapy and surgery for gender reassignment, which can involve genital reconstruction surgery and breast/chest surgery. For the FtM patient, surgical procedures may include mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy, vulvectomy, scrotoplasty, urethroplasty, placement of testicular and/or penile prostheses and phalloplasty or metoidioplasty (alternative to phalloplasty). For the MtF patient, surgical procedures may include penectomy, vaginoplasty, clitoroplasty, labiaplasty, orchiectomy and urethroplasty.

Other terms used to describe surgery for Gender Dysphoria include sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex reassignment.

BENEFIT CONSIDERATIONS

Coverage Information

Unless otherwise specified, if a plan covers treatment for gender dysphoria, coverage includes psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments listed in the [Coverage Rationale](#) section. See the Medical Benefit Drug Policy titled [Gonadotropin Releasing Hormone Analogs](#).

Limitations and Exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatment received outside of the United States
- Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus (please check the federal, state or contractual requirements for benefit coverage)
- Transportation, meals, lodging or similar expenses
- Cosmetic procedures (see Coverage Determination Guideline titled [Cosmetic and Reconstructive Procedures](#) and the [Coverage Rationale](#) section)
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

Benefits are limited to one sex transformation reassignment per lifetime which may include several staged procedures.

Coverage does not apply to members who do not meet the indications listed in the [Coverage Rationale](#) section.

CLINICAL EVIDENCE

An ECRI special report systematically reviewed the clinical literature to assess the efficacy of treatments for gender dysphoria. The authors identified limited evidence from mostly low-quality retrospective studies. Evidence on gender reassignment surgery was mostly limited to evaluations of MtF individuals undergoing vaginoplasty, facial feminization surgery and breast augmentation. Outcomes included mortality, patient satisfaction, physical well-being, psychological-related outcomes, quality of life, sexual-related outcomes, suicide and adverse events. Concluding remarks included the need for standardized protocols and prospective studies using standardized measures for correct interpretation and comparability of data (ECRI, 2016).

A Hayes report concluded that, overall, the quality of the evidence on gender reassignment surgery for gender dysphoria was very low (Hayes, 2014a; updated 2018). The evidence suggests positive benefits, but because of serious limitations, permits only weak conclusions. Limitations include small sample sizes, retrospective data, lack of randomization and control and a lack of objective and validated outcome measures.

- Patients who underwent chest/breast or genital surgery were generally pleased with the aesthetic results.
- Following gender reassignment surgery, patients reported decreased gender dysphoria, depression and anxiety and increased quality of life.
- The majority of gender reassignment surgery patients were sexually active, but the ability to orgasm varied across studies.
- Complications of surgery following gender reassignment surgery were common and could be serious.
- Rates of regret of surgery and suicide were very low following gender reassignment surgery.
- Data were too sparse to draw conclusions regarding whether gender reassignment surgery conferred additional benefits to hormone therapy alone.
- Data were too sparse to draw conclusions regarding whether outcomes vary according to which surgeries were performed.

A separate Hayes report concluded that, overall, the quality of the evidence on ancillary procedures for the treatment of gender dysphoria was very low (Hayes, 2014b; updated 2018). There is some evidence that transgender patients are satisfied with the results of rhinoplasty and facial feminization surgery, but patient satisfaction with vocal cord surgery and voice training was mixed. The evidence has serious limitations, and the effect of these procedures on overall individual well-being is unknown.

- Patients who had rhinoplasty or facial feminization surgery were generally pleased with the results.
- Vocal cord procedures and voice training had variable outcomes. Although the fundamental frequency was reduced by all treatment methods, patient satisfaction with the outcome was mixed.
- Most of the studies did not report complications; however, there was a low rate of bone nonunion following facial surgery, and moderate rates of dysphagia or throat pain following cricothyroid approximation.

Mahfouda et al. (2019) conducted a systematic review of the the available published evidence on gender-affirming cross-sex hormone (CSH) and surgical interventions in transgender children and adolescents, amalgamating findings on mental health outcomes, cognitive and physical effects, side-effects, and safety variables. The small amount of available data suggest that when clearly indicated in accordance with international guidelines, gender-affirming CSHs and chest wall masculinisation in transgender males are associated with improvements in mental health and quality of life. Evidence regarding surgical vaginoplasty in transgender females younger than age 18 years remains extremely scarce and conclusions cannot yet be drawn regarding its risks and benefits in this age group. Further research on an international scale is urgently warranted to clarify long-term outcomes on psychological functioning and safety.

Dreher et al. (2018) conducted a systematic review and meta-analysis to evaluate the epidemiology, presentation, management, and outcomes of neovaginal complications in the MtF transgender reassignment surgery patients. Selected studies reported on 1,684 patients with an overall complication rate of 32.5% and a reoperation rate of 21.7% for non-esthetic reasons. The most common complication was stenosis of the neo-meatus (14.4%). Wound infection was associated with an increased risk of all tissue-healing complications. Use of sacrospinous ligament fixation (SSL) was associated with a significantly decreased risk of prolapse of the neovagina. The authors concluded that gender-affirmation surgery is important in the treatment of gender dysphoric patients, but there is a high complication rate in the reported literature. Variability in technique and complication reporting standards makes it difficult to assess the accurately the current state of MtF gender reassignment surgery. Further research and implementation of standards is necessary to improve patient outcomes.

Manrique et al (2018) conducted a systematic review of retrospective studies on the outcomes of MtF vaginoplasty to minimize surgical complications and improve patient outcomes for transgender patients. Forty-six studies met the authors eligibility criteria. A total of 3716 cases were analyzed. The results showed the overall incidence of complications as follows: 2% fistula, 14% stenosis and strictures, 1% tissue necrosis, and 4% prolapse. Patient-reported outcomes included a satisfaction rate of 93% with overall results, 87% with functional outcomes, and 90% with esthetic outcomes. Ability to have orgasm was reported in 70% of patients. The regret rate was 1%. The authors concluded that multiple surgical techniques have demonstrated safe and reliable means of MtF vaginoplasty with low overall complication rates and with a significant improvement in the patient's quality of life. Studies using different techniques in a similar population and standardized patient-reported outcomes are required to further analyze outcomes among the different procedures and to establish best-practice guidelines.

Van Damme et al. (2017) conducted a systematic review of the effectiveness of pitch-raising surgery performed in MtF transsexuals. Twenty studies were included: eight using cricothyroid approximation, six using anterior glottal web formation and six using other surgery types or a combination of surgical techniques. A substantial rise in postoperative frequency was identified. The majority of patients seemed satisfied with the outcome. However, none of the studies used a control group and randomization process. Further investigation regarding long-term results using a stronger study design is necessary.

Morrison et al. (2016) conducted a systematic review of the facial feminization surgery literature. Fifteen studies were included, all of which were either retrospective or case series/reports. The studies covered a variety of facial feminization procedures. A total of 1121 patients underwent facial feminization surgery, with seven complications reported, although many studies did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors noted that further studies are needed to better compare different techniques to more robustly establish best practices. Prospective studies and patient-reported outcomes are needed to establish quality of life outcomes for patients.

Frey et al. (2016) conducted a systematic review of metoidioplasty and radial forearm flap phalloplasty (RFFP) in FtM transgender genital reconstruction. Eighteen studies were included: 7 for metoidioplasty and 11 for RFFP. The quality of evidence was low to very low for all included studies. In studies examining metoidioplasty, the average study size and length of follow-up were 54 patients and 4.6 years, respectively (1 study did not report [NR]). Eighty-eight percent underwent a single-stage reconstruction, 87% reported an aesthetic neophallus (3 NR) and 100% reported erogenous sensation (2 NR). Fifty-one percent of patients reported successful intercourse (3 NR) and 89% of patients achieved standing micturition (3 NR). In studies examining RFFP, the average study size and follow-up were 60.4 patients and 6.23 years, respectively (6 NR). No patients underwent single-stage reconstructions (8 NR). Seventy percent of patients reported a satisfactorily aesthetic neophallus (4 NR) and 69% reported erogenous sensation (6 NR). Forty-three percent reported successful penetration of partner during intercourse (6 NR) and 89% achieved standing micturition (6 NR). Compared with RFFP, metoidioplasty was significantly more likely to be completed in a single stage, have an aesthetic result, maintain erogenous sensation, achieve standing micturition and have a lower overall complication rate. The authors reported that, although the current literature suggests that metoidioplasty is more likely to yield an "ideal" neophallus compared with RFFP, any conclusion is severely limited by the low quality of available evidence.

Using a retrospective chart review, Buncamper et al. (2016) assessed surgical outcome after penile inversion vaginoplasty. Outcome measures were intraoperative and postoperative complications, reoperations, secondary surgical procedures and possible risk factors. Of 475 patients who underwent the procedure, 405 did not have additional full-thickness skin grafts while 70 did have grafts. Median follow-up was 7.8 years. The most frequently observed intraoperative complication was rectal injury (2.3 percent). Short-term postoperative bleeding that required transfusion (4.8 percent), reoperation (1.5 percent) or both (0.4 percent) occurred in some cases. Major complications were three (0.6 percent) rectovaginal fistulas, which were successfully treated. Revision vaginoplasty was performed in 14 patients (2.9 percent). Comorbid diabetes was associated with a higher risk of local infection, and use of psychotropic medication predisposed to postoperative urinary retention. Successful vaginal construction without the need for secondary functional reoperations was achieved in the majority of patients.

Bouman et al. (2016) prospectively assessed surgical outcomes of primary total laparoscopic sigmoid vaginoplasty in 42 transgender women with penoscrotal hypoplasia. Mean follow-up time was 3.2 ± 2.1 years. The mean operative duration was 210 ± 44 minutes. There were no conversions to laparotomy. One rectal perforation was recognized during surgery and immediately oversewn without long-term consequences. The mean length of hospitalization was 5.7 ± 1.1 days. One patient died as a result of an extended-spectrum beta-lactamase-positive necrotizing fasciitis leading to septic shock, with multiorgan failure. Direct postoperative complications that needed laparoscopic reoperation occurred in three cases (7.1 percent). In seven cases (17.1 percent), long-term complications needed a secondary correction. After 1 year, all patients had a functional neovagina with a mean depth of 16.3 ± 1.5 cm.

Despite the significant increase in genital gender affirming surgery (GAS) within the past 50 years, there is limited data regarding hair removal practices in preparation for genital GAS. Genital gender affirming surgery (GAS) involves reconstruction of the genitals to match a patient's identified sex. The use of hair-bearing flaps in this procedure may result in postoperative intra-vaginal and intra-urethral hair growth and associated complications, including lower satisfaction with genital GAS. In 2016 Zhang et al conducted a literature review, recommendations from experience, and a practical laser hair removal (LHR) approach to hair removal prior to genital GAS.

Gaither et al. (2017) retrospectively reviewed the records of 330 MtF patients from 2011 to 2015, to assess surgical complications related to primary penile inversion vaginoplasty. Complications included granulation tissue, vaginal pain, wound separation, labial asymmetry, vaginal stenosis, fistula formation, urinary symptoms including spraying stream or dribbling, infection, vaginal fissure or vaginal bleeding. Median age at surgery was 35 years, and median followup in all patients was 3 months. The results showed that 95 of the patients presented with a postoperative complication with the median time to a complication being 4.4 months. Rectovaginal fistulas developed in 3 patients, and 30 patients required a second operation. Age, body mass index and hormone replacement therapy were not associated with complications. The authors concluded that penile inversion vaginoplasty is a relatively safe procedure. Most complications due to this surgery develop within the first 4 months postoperatively. Age, body mass index and hormone replacement therapy are not associated with complications and, thus, they should not dictate the timing of surgery.

Horbach et al. (2015) conducted a systematic review of vaginoplasty techniques in MtF individuals with gender dysphoria. Twenty-six studies were included (mostly retrospective case series of low to intermediate quality). Outcome of the penile skin inversion technique was reported in 1,461 patients and bowel vaginoplasty in 102 patients. Neovaginal stenosis was the most frequent complication in both techniques. Sexual function and patient satisfaction were overall acceptable, but many different outcome measures were used. Quality of life was only reported in one study. Comparison between techniques was difficult due to the lack of standardization. The authors concluded that the penile skin inversion technique is the most researched surgical procedure. Outcome of bowel vaginoplasty has been reported less frequently but does not seem to be inferior. The available literature is heterogeneous in patient groups, surgical procedure, outcome measurement tools and follow-up. There is a need for prospective studies with standardized surgical procedures, larger patient groups and longer follow-up periods. Uniformity in outcome measurement tools such as validated questionnaires and scores for sexual function and quality of life is mandatory for correct interpretation and comparability of data.

Bouman et al. (2014) conducted a systematic review of surgical techniques and clinical outcomes of intestinal vaginoplasty. Twenty-one studies were included (n=894). All studies had a retrospective design and were of low quality. Prevalence and severity of procedure-related complications were low. The main postoperative complication was introital stenosis, necessitating surgical correction in 4.1% of sigmoid-derived and 1.2% of ileum-derived vaginoplasties. Neither diversion colitis nor cancer was reported. Sexual satisfaction rate was high, but standardized questionnaires were rarely used. Quality of life was not reported. The authors concluded that prospective studies, using standardized measures and questionnaires, are warranted to assess functional outcomes and quality of life.

Murad et al. (2010) conducted a systematic review to evaluate the effects of hormone therapy on patients undergoing gender reassignment surgery. The authors identified 28 eligible studies, all of which were observational and most lacked controls. These studies enrolled 1833 participants with gender dysphoria (1093 MtF; 801 FtM). After gender

reassignment surgery, individuals reported improvement in gender dysphoria (80%), psychological symptoms (78%), sexual function (72%) and quality of life (80%). The authors concluded that very low quality evidence suggests that gender reassignment, that includes hormonal interventions, is likely to improve gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.

Sutcliffe et al. (2009) systematically reviewed five individual procedures for MtF gender reassignment surgery: clitoroplasty, labiaplasty, orchiectomy, penectomy and vaginoplasty. Further evaluations were made of eight surgical procedures for FtM gender reassignment surgery: hysterectomy, mastectomy, metoidioplasty, phalloplasty, salpingo-oophorectomy, scrotoplasty/placement of testicular prostheses, urethroplasty and vaginectomy. Eighty-two published studies (38 MtF; 44 FtM) were included in the review. For MtF procedures, the authors found no evidence that met the inclusion criteria concerning labiaplasty, penectomy or orchiectomy. A large amount of evidence was available concerning vaginoplasty and clitoroplasty procedures. The authors reported that the evidence concerning gender reassignment surgery in both MtF and FtM individuals with gender dysphoria has several limitations including lack of controlled studies, lack of prospective data, high loss to follow-up and lack of validated assessment measures. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence.

Djordjevic et al. (2013) evaluated 207 patients who underwent single-stage metoidioplasty, comparing two different surgical techniques of urethral lengthening. The procedure included lengthening and straightening of the clitoris, urethral reconstruction and scrotoplasty with implantation of testicular prostheses. Buccal mucosa graft was used in all cases for dorsal urethral plate formation and joined with one of the two different flaps: longitudinal dorsal clitoral skin flap (n=49) (group 1) and labia minora flap (n=158) (group 2). The median follow-up was 39 months. The total length of reconstructed urethra ranged from 9.1 to 12.3 cm in group 1 and from 9.4 to 14.2 cm in group 2. Voiding while standing was significantly better in group 2 (93%) than in group 1 (87.82%). Urethral fistula occurred in 16 patients in both groups. Overall satisfaction was noted in 193 patients. The authors concluded that combined buccal mucosa graft and labia minora flap was the method of choice for urethroplasty in metoidioplasty, minimizing postoperative complications.

A single-arm study by Weigert et al. (2013) evaluated patient satisfaction with breasts and psychosocial, sexual and physical well-being after breast augmentation in MtF individuals with gender dysphoria. Thirty-five patients were asked to complete the BREAST-Q Augmentation module questionnaire before surgery, at 4 months and later after surgery. A prospective cohort study was designed and postoperative scores were compared with baseline scores. Responses indicated significant improvements in satisfaction with surgery (+59 points), psychosocial well-being (+48 points) and sexual well-being (+34 points). No significant changes were reported for physical well-being. This study has several limitations including lack of a control group and subjective measures.

In a non-randomized study, Dhejne et al. (2011) evaluated mortality, morbidity and criminal rates after gender reassignment surgery in 324 individuals (MtF n=191; FtM n=133). Random population controls (10:1) were matched by birth year and birth sex or reassigned final sex. The authors reported substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts and psychiatric hospitalizations in sex-reassigned individuals (both MtF/FtM) compared to a healthy control population. FtMs had a higher risk for criminal convictions.

World Professional Association for Transgender Health (WPATH)

WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, is an advocacy group devoted to transgender health. WPATH guidelines (2012) present eligibility and readiness criteria for transition-related treatment, as well as competencies of health care providers.

WPATH describes the transition from one gender to another in the following three stages:

- Living in the gender role consistent with gender identity
- The use of cross-sex hormone therapy after living in the new gender role for a least three months
- Gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months

Professional Societies

American College of Obstetrics and Gynecology (ACOG)

An ACOG committee opinion (2017) provides guidance on health care for transgender adolescents. The document makes the following recommendations regarding surgery:

- Obstetrician-gynecologists should understand gender identity and be able to treat transgender patients or refer them appropriately for medical and surgical therapeutic options.
- Surgical management for transgender male patients is typically reserved for patients 18 years and older.
- For transgender male patients, phalloplasty may be performed when the patient reaches the age of majority.
- Transgender female patients who choose to undergo surgery for a neovagina may have vaginoplasty after the age of majority.
- Transgender patients should be counseled about fertility and fertility preservation prior to surgical treatment.

A separate ACOG committee opinion (2011) provides guidance on health care for transgender individuals. The document makes the following recommendations regarding surgery:

- Obstetrician-gynecologists should assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies.
- Hormonal and surgical therapies should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender persons.

Endocrine Society

Endocrine Society practice guidelines (Hembree et al., 2017) addressing endocrine treatment of gender-dysphoric/gender-incongruent persons makes the following recommendations regarding surgery for sex reassignment and gender confirmation:

- Suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country (Recommendation based on low quality evidence).
- A patient pursue genital gender-affirming surgery only after the mental health practitioner (MHP) and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being (Strong recommendation based on low quality evidence).
- Surgery is recommended only after completion of at least one year of consistent and compliant hormone treatment unless hormone therapy is not desired or medically contraindicated (Ungraded Good Practice Statement).
- The physician responsible for endocrine treatment medically clears individual for surgery and collaborates with the surgeon regarding hormone use during and after surgery (Ungraded Good Practice Statement).
- Recommend that clinicians refer hormone treated transgender individuals for genital surgery when (Strong recommendation based on very low quality evidence):
 - The individual has had a satisfactory social role change
 - The individual is satisfied about the hormonal effects
 - The individual desires definitive surgical changes
- Suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement (Recommendation based on very low quality evidence).

American Academy of Pediatrics (AAP)

In a 2018 policy statement entitled Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, the AAP states the following regarding surgery: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults, they are occasionally pursued during adolescence on a case-by case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Gender reassignment surgeries are procedures, and therefore, not subject to FDA regulation. However, medical devices, drugs, biologics or tests used as a part of these procedures may be subject to FDA regulation. See the following website to search by product name: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed June 4, 2019)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does have a National Coverage Determination (NCD) for [Gender Dysphoria and Gender Reassignment Surgery \(140.9\)](#). Local Coverage Articles (LCAs) also exist; refer to the LCAs for [Gender Reassignment Services for Gender Dysphoria](#). (Accessed June 4, 2019)

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2020	<p>Applicable Codes</p> <ul style="list-style-type: none"> • Updated list of applicable CPT codes to reflect annual code edits: <ul style="list-style-type: none"> ○ Added 15769, 15771, 15772, 15773, and 15774 ○ Removed 19304 and 20926 <p>Supporting Information</p> <ul style="list-style-type: none"> • Archived previous policy version CS145.E

INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

EXHIBIT G

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,)
)
Plaintiff,)
)
vs.) 4:19-cv-00035
)
STATE OF ARIZONA; ARIZONA BOARD)
OF REGENTS, D/B/A UNIVERSITY OF)
ARIZONA, a governmental body of)
the State of Arizona; et al.,)
)
Defendants.)
)

VIDEOTAPED DEPOSITION OF MARIE FRANCES ISAACSON

Via Zoom videoconference
March 26, 2021
8:21 a.m.

Glennie Reporting Services, LLC
1555 East Orangewood Avenue
Phoenix, Arizona 85020

602.266.6535
www.glennie-reporting.com

Prepared by:

Jill Marnell, RPR
Arizona Certified
Reporter No. 50021

Marie Frances Isaacson - 03/26/2021

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1 Q. And what about -- what is it about bariatric
2 surgery that sticks out in your mind?

3 A. Just what type of procedure -- there are
4 different types -- there are different ways of conducting
5 it, and we wanted to cover the gastric sleeve. We wanted
6 to add that as a benefit.

7 Q. And when was that work?

8 A. 2013 maybe.

9 Q. And was it -- was that work almost all in 2013 or
10 did it go on for a number of years?

11 A. It -- it was for the plan design for the
12 following year.

13 Q. So in 2013 you recall working on what coverage
14 the plan provided for bariatric surgery?

15 A. That's right.

16 Q. Do you recall ever working on any other -- And to
17 clarify, did the plan exclude coverage for bariatric
18 surgery at that point?

19 A. I didn't exclude it, but I think it covered
20 specific types of bariatric surgery. It may have excluded
21 it. I honestly don't remember. As I recall, it was to
22 include that type of bariatric surgery.

23 Q. How did that process begin?

24 A. Two of the managers in the benefits division came
25 to me with the recommendation to include gastric sleeve.

Marie Frances Isaacson - 03/26/2021

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1 Q. And is gastric sleeve the type of bariatric
2 surgery the plan was considering covering?

3 A. Adding, yes.

4 Q. Is that typically how extensions of benefits come
5 to your -- came to your attention?

6 A. Yes.

7 Q. So someone working in the benefit services
8 division would come to you and say the plan should cover a
9 particular type of service or treatment?

10 A. Yes.

11 Q. Did you ever -- did you ever get such requests
12 top down, say, from a supervisor?

13 A. No.

14 Q. And do you know where those two -- So speaking
15 specifically -- speaking with respect to the bariatric
16 surgery -- and I think it was a type of sleeve, gastric
17 sleeve -- do you know where those two managers got the
18 idea that the plan might -- should cover or should
19 consider extending coverage for gastric sleeves?

20 A. I'm guessing from the health plans.

21 Q. And what do you mean by the health plans?

22 A. Aetna, Cigna, United, Blue Cross Blue Shield.

23 Q. And why would that be your guess?

24 A. Just knowing the functioning of benefits and how
25 it works.

Marie Frances Isaacson - 03/26/2021

100

1 Q. Is it typical for the health plans to come to the
2 ADOA recommending that coverage be extended for treatment?

3 A. I -- I would say it's typical that the health
4 plans come to DOA with various recommendations: what to
5 cover, what not to cover, changes to make.

6 Q. How often would you say, in your time working at
7 ADOA, this happened?

8 A. That they recommended changes?

9 Q. Yes.

10 A. We met -- we met regularly. We met -- I -- I
11 can't remember how often. Quarterly at least with the
12 health plans. I can't say that each of those meetings
13 resulted in recommendations of change. It was more how
14 the -- how the plan was doing, a review of -- of the plan
15 and utilization.

16 Q. So continuing to focus on this gastric sleeve for
17 bariatric surgery, do you recall the outcome of that
18 inquiry?

19 A. It was added as a benefit.

20 Or I should say, to be clear, extended a
21 benefit. So for the type of surgery.

22 Q. Does that make a difference, whether a benefit is
23 being added or extended?

24 A. I just wanted to be clear. It wasn't new, it was
25 just an extension of the type of surgery we would cover.

Marie Frances Isaacson - 03/26/2021

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1 Q. Thank you for clarifying that, Ms. Isaacson. But
2 my question remains, does it make a difference whether the
3 ADOA is considering whether to add a benefit or extend
4 benefits?

5 A. I'm not sure I'm following your question.

6 Q. Sure. Is -- is there a standard process for when
7 the insurers bring a recommendation on whether the plan
8 should cover a benefit?

9 A. The process is that they bring the -- the
10 recommendation and then we discuss it amongst ourselves --
11 we discussed it amongst ourselves, and then we would raise
12 it to the director's office.

13 Q. And how long would that process typically take?

14 A. I'd say plan design started in June and was ready
15 in -- I'm sorry, let me backtrack.

16 I would say it starts -- in the beginning of
17 the plan year is when you start looking at your plan and
18 what happens. And it results in a plan design change by
19 June. So six months.

20 Q. Do you recall if it took -- Do you recall with
21 respect to this gastric sleeve or bariatric surgery
22 whether it took the six months?

23 A. I don't recall specifically, but that's about the
24 time frame. I'm not sure how long the plans brought that
25 idea forward.

Marie Frances Isaacson - 03/26/2021

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1 Q. Were there any changes to the plan that the
2 director's office can make themselves?

3 A. You know, there -- As an example, a pharmacy
4 change, to change from one type of drug to a different
5 drug to save money, that would be recommended by the
6 pharmacy benefit manager. And that -- that wasn't,
7 though, a contribution strategy discussion. That was --
8 that could have been midyear. And that -- I would have
9 brought that to the director's office and they would make
10 a determination as to whether or not the governor's office
11 would be notified of that. I'm not sure when they did or
12 didn't notify the governor's office of those types of
13 decisions.

14 For plan design and the contribution
15 strategy the governor's office was always involved.

16 Q. So to be clear, yes, there were some decisions
17 that the director's office can make themselves.

18 A. I -- I don't know because I don't know every
19 decision that was run by the governor's office or not.

20 Q. But do you know whether the governor -- the
21 director's office could make a decision, for example, on
22 pharmacy benefits by themselves?

23 A. I don't know the answer to that.

24 Q. Was there anyone else beyond the director's
25 office and the governor's office who was involved in

Marie Frances Isaacson - 03/26/2021

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1 her through the -- when you were at the ADOA?

2 A. I -- Yeah, I -- Yes.

3 Q. Has there ever been a conflict of interest in
4 your work with the Arizona governor's office because of
5 your prior work at the ADOA?

6 A. No.

7 Q. So just to be clear, there's never been a matter
8 that you didn't feel like you could approach the
9 governor's office because of your prior work with the
10 ADOA?

11 A. Correct.

12 Q. And are you aware whether the Isaacson Law Firm
13 ever screened you off from anything because of your work
14 at the ADOA?

15 A. No.

16 Q. So -- And, again, we're going to pivot to your --
17 to your work as the benefits director, you know, in the
18 last role -- your last role in the ADOA. But just before
19 that, on the bariatric surgery and gastric sleeve
20 procedure we've been discussing, I believe you said
21 earlier that procedure was ultimately approved.

22 A. Correct.

23 Q. Was that procedure legally required?

24 A. No.

25 Q. Why was it approved?

Marie Frances Isaacson - 03/26/2021

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1 A. Best interest of the plan and members.

2 Q. When you say the best interest of the plan what
3 do you mean by that?

4 A. It was a preferred type of surgery with less
5 complications, fewer complications for the patient.

6 Q. And who made that assessment?

7 A. I'm assuming we got it from the medical directors
8 of the plans.

9 Q. So does the ADOA have an interest in -- When you
10 say it's a preferred type of surgery with less
11 complications, fewer complications for the patient, does
12 the plan or the ADOA I guess, whichever it is, have an
13 interest in making it -- making services less complicated?

14 A. When I say "less complicated" I meant medically
15 less complicated. So better outcomes, better for the
16 patient.

17 Q. And --

18 A. (Indecipherable) complications.

19 THE COURT REPORTER: I'm sorry?

20 THE WITNESS: Fewer complications.

21 Q. BY MR. WALL: And is the welfare of the patients
22 a priority for the ADOA?

23 A. Yes.

24 Q. And forgive me, you might have testified to this
25 earlier. But was there a cost analysis of providing for

Marie Frances Isaacson - 03/26/2021

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1 gastric sleeves done?

2 A. I don't recall.

3 Q. Do you have any reason to doubt that there would
4 have been one?

5 A. I just don't know one way or the other.

6 Q. Now, just to be clear, is your answer that you
7 don't -- you don't know or you just don't recall? Like
8 you might have known at one point but you can no longer
9 remember?

10 A. I no longer remember.

11 Q. Would you ever present a treatment like the
12 gastric sleeve to the director's office without a cost
13 analysis?

14 A. Probably not.

15 Q. And what -- would you ever present a cost
16 analysis to the director's office that hadn't been
17 certified by an actuary?

18 A. There may have been.

19 Q. So the answer is yes, you might present to the
20 director's office a cost analysis that wasn't certified.

21 A. Unlikely, but perhaps.

22 Q. Why is that unlikely?

23 A. Because there was always -- because the plan was
24 self-funded there was always a concern for what impact it
25 would have on the plan, the health of the plan, and the

Marie Frances Isaacson - 03/26/2021

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1 than what is -- what we consider in the best interest of
2 the patient. That's what I was trying to get to.

3 Q. BY MR. WALL: And Ms. Isaacson, I think you might
4 have answered this but to be clear, do you recall whether
5 there was an actuarial analysis of the cost of covering
6 this gastric sleeve procedure?

7 A. I don't recall.

8 Q. Would you be surprised if there was not an
9 actuarial cost analysis?

10 A. Yes.

11 Q. Other than the best interest of the plan and the
12 patient and an actuarial cost analysis, do you recall any
13 other criteria that was evaluated in deciding to remove
14 this exclusion from the plan?

15 A. No.

16 Q. Was the legal necessity of this surgery a factor
17 in deciding to remove this exclusion from the plan?

18 A. No.

19 Q. And why not?

20 A. It was already -- the procedure was already
21 covered. It was just the type of procedure. The -- the
22 method of the procedure, the gastric sleeve was one method
23 of gastric bypass surgery.

24 Q. So when you say the procedure was already
25 covered, do you mean that there were -- So let me -- let

1 STATE OF ARIZONA)
) ss.
 2 COUNTY OF YAVAPAI)

3 BE IT KNOWN that the foregoing proceedings were
 4 taken before me; that the witness before testifying was
 5 duly sworn by me to testify to the whole truth; that the
 6 foregoing pages are a full, true, and accurate record of
 7 the proceedings, all done to the best of my skill and
 8 ability; that the proceedings were taken down by me in
 9 shorthand and thereafter reduced to print under my
 10 direction.

11 I CERTIFY that I am in no way related to, nor
 12 employed by any of the parties hereto, and have no
 13 interest in the outcome thereof.

14 [X] Review and signature was requested.
 15 [] Review and signature was waived.
 16 [] Review and signature not requested.

17 I CERTIFY that I have complied with the ethical
 18 obligations set forth in ACJA 7-206(F)(3) and ACJA
 19 7-206(J)(1)(g)(1) and (2). Dated at Prescott, Arizona,
 20 this 8th day of April, 2021.

21 

22 _____
 23 JILL MARNELL
 24 Certified Reporter #50021
 25 Registered Professional Reporter

* * * * *

26 I CERTIFY that GLENNIE REPORTING SERVICES, LLC, has
 27 complied with the ethical obligations set forth in ACJA
 28 7-206(J)(1)(g)(1) through (6).

29 _____
 30 GLENNIE REPORTING SERVICES, LLC
 31 Registered Reporting Firm
 32 Arizona RRF No. R1035

EXHIBIT H

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,)
)
 Plaintiff,)
)
 vs.) 4:19-CV-00035
)
 STATE OF ARIZONA; ARIZONA BOARD)
 OF REGENTS, d/b/a UNIVERSITY OF)
 ARIZONA, a governmental body of)
 the State of Arizona; et al.,)
)
 Defendants.)
 _____)

VIDEOTAPED DEPOSITION OF SCOTT BENDER

Via Zoom Videoconference
March 31, 2021
8:00 a.m.
Phoenix, Arizona

Glennie Reporting Services, LLC
1555 East Oranewood Avenue
Phoenix, Arizona 85020
602.266.6535
www.glenne-reporting.com

Prepared by:
Robin L. B. Osterode
CSR, RPR
CA CSR No. 7750
AZ CR No. 50695

Scott Bender, Videotaped - 03/31/2021

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1 how often does that occur?

2 A. Not very frequently.

3 Q. Twice a year?

4 A. No, not even that often.

5 Q. Once every two years?

6 A. I'd say that's probably more -- more likely.

7 And, typically, it's done in conjunction with change in
8 law that we have to, you know, cover something in
9 particular.

10 Q. Was the removal of the plan's exclusion of 3-D
11 mammography the last plan exclusion you dealt with?

12 A. No, it was the -- the clinical cancer trial.
13 And that was something that we had to cover. 3-D
14 mammography was more of a change in medical coverage
15 guidelines.

16 Q. So what do you mean it -- what do you mean by
17 it was a "change in medical coverage guidelines"?

18 A. The vendors themselves determine what is
19 considered a medically necessary service. As I
20 mentioned, Aetna was the first organization to make the
21 determination that 3-D mammography was an appropriate
22 service and not experimental. They had seen enough
23 evidence to determine that that is something that should
24 be covered. And they were covering it on their -- on
25 their medical guidelines. And slowly, but surely, the

Scott Bender, Videotaped - 03/31/2021

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1 others evolved. And my recollection is that that had
2 previously been listed as an exclusion, and that was
3 taken off.

4 Q. When you say the others evolved, are you
5 referring to the then-network providers?

6 A. Yes. So Cigna and Blue Cross Blue Shield and
7 United Healthcare, their coverage guidelines ultimately
8 went under the same sort of review of medical compendia
9 and data, and they determined that that should be more a
10 standard service than an experimental service.

11 Q. Over how long a period did this occur? For
12 instance, when did Aetna add in 3-D mammography to its --
13 to its guidelines?

14 A. I don't know when they added it. I want to say
15 it was in 2018. And over a period of probably about a
16 year, is my recollection, the other vendors came to the
17 same determination.

18 I lost video of them.

19 Q. Oh, can you see me?

20 A. No, I -- we seem to have a little --

21 MR. CURTIS: Can we go off the record for a
22 moment?

23 THE WITNESS: -- mousepad here. I don't even
24 have a mouse; it's moving on its own.

25 THE REPORTER: Do you want to go off the

Scott Bender, Videotaped - 03/31/2021

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1 who is not, and what is the basis for that.

2 Q. Did you ask Ms. Medina to do a cost analysis of
3 covering the treatment?

4 A. I don't recall. I don't believe so.

5 Q. Would you have likely asked her to do a cost
6 analysis?

7 A. Very likely. Either her or our actuary. But
8 my recollection was the cost is fairly similar, so it
9 wouldn't have been an extreme cost burden to the plan.

10 Q. Fairly similar to what?

11 A. Excuse me, similar to a standard mammogram. So
12 the standard mammogram that was replaced by a 3-D
13 mammography. And the standard is still being used out
14 there very broadly, even though 3-D's available.

15 Q. And it was important that the cost of the 3-D
16 mammography was similar to a service the plan was already
17 covering?

18 A. Any time you're considering additional costs,
19 it's important to understand what that is. My
20 recollection was that the cost for a 3-D mammography was
21 very similar to the cost of a standard mammogram.

22 Q. And the fact that it was similar meant that it
23 would be less impactful?

24 A. Correct.

25 Q. Now, Mr. Bender, you said earlier you expect

1 STATE OF ARIZONA)
2 COUNTY OF MARICOPA)

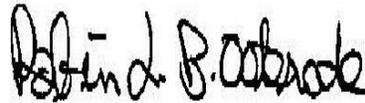
3 BE IT KNOWN that the foregoing proceedings
4 were taken before me; that the witness before testifying
5 was duly sworn by me to testify to the whole truth; that
6 the foregoing pages are a full, true, and accurate record
7 of the proceedings all done to the best of my skill and
8 ability; that the proceedings were taken down by me in
9 shorthand and thereafter reduced to print under my
10 direction.

11 [X] Review and signature was requested.

12 [] Review and signature was waived.

13 [] Review and signature not required.

14 I FURTHER CERTIFY that I have complied with
15 the ethical obligations set forth in the ACJA 7-206(F)(3)
16 and ACJA 7-206(J)(1)(g)(1) and (2). Dated at Phoenix,
17 Arizona, this 13th day of April, 2021.

18 

19 _____
20 ROBIN L. B. OSTERODE, RPR
21 CA CSR No. 7750
22 AZ CR No. 50695

23 * * * * *

24 I CERTIFY that Glennie Reporting Services,
25 LLC, has complied with the ethical obligations set forth
in ACJA 7-206(J)(1)(g)(1) through (6).

26 _____
27 GLENNIE REPORTING SERVICES, LLC
28 Registered Reporting Firm
29 Arizona RRF No. R1035

EXHIBIT I

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,)
)
Plaintiff,)
)
vs.) 4:19-cv-00035
)
STATE OF ARIZONA; ARIZONA BOARD)
OF REGENTS, D/B/A UNIVERSITY OF)
ARIZONA, a governmental body of)
the State of Arizona; et al.,)
)
Defendants.)
)

VIDEOTAPED DEPOSITION OF ELIZABETH MARIE SCHAFER

Via Zoom videoconference
April 28, 2021
8:33 a.m.

Glennie Reporting Services, LLC
1555 East Oranewood Avenue
Phoenix, Arizona 85020

602.266.6535
www.glenzie-reporting.com

Prepared by:

Jill Marnell, RPR
Arizona Certified
Reporter No. 50021

Elizabeth Schafer, Videotaped - 04/28/2021

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1 that are more expensive than that.

2 Q. BY MR. GARBACZ: Do you know if ADOA has added
3 things that are more expensive than that or that added
4 benefits that are more expensive than that in your tenure
5 at the ADOA?

6 A. No. I'm sure they added stuff but I wouldn't
7 know the cost of each addition.

8 Q. Can you think of an example of something that
9 might have cost more than that that ADOA added in your
10 time at ADOA?

11 A. I know we add -- like we added the drugs to take
12 care of hepatitis C, which is an extremely expensive drug,
13 because it cured people. So I know we added things like
14 that.

15 Q. Let's take that example for a minute. Do you
16 remember what the name of that drug was?

17 A. No.

18 Q. But it's a hepatitis -- hepatitis C drug?

19 A. Right. And it -- it actually cures the person of
20 the disease so we -- then we stop getting claims from that
21 person. So it's worth the large expense.

22 Q. So if a procedure cures someone of a disorder,
23 that's a reason to cover it. Yes?

24 A. Yes.

25 Q. Do you remember generally what the cost was for

Elizabeth Schafer, Videotaped - 04/28/2021

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1 covering -- I know you said it was expensive, but do you
2 have any -- any detail about how much it may have cost?

3 A. I think it's over a million dollars for one
4 member.

5 Q. Do you remember whether the trend was to cover
6 that? Were other -- were other self-funded plans covering
7 that drug?

8 A. Yeah, it's very common. A lot of people added it
9 because down the road it cuts down your claims. So you
10 want to cure people of hepatitis C if you can.

11 THE COURT REPORTER: And you're saying
12 hepatitis C, as in cat?

13 THE WITNESS: Correct.

14 Q. BY MR. GARBACZ: Okay. Other than this drug for
15 hepatitis C, are there any other instances of a -- of a
16 benefit that comes to mind, specifically a benefit that
17 has added more than 17 cents per employee per month?

18 A. I honestly don't really remember, you know, the
19 cost of every change that was made to the plan, so I can't
20 think of anything else.

21 Q. Let's take just a couple of examples of things
22 that we had spoken about earlier. We talked about 3D
23 mammography.

24 A. Uh-huh.

25 Q. Right?

1 STATE OF ARIZONA)
) ss.
 2 COUNTY OF YAVAPAI)

3 BE IT KNOWN that the foregoing proceedings were
 4 taken before me; that the witness before testifying was
 5 duly sworn by me to testify to the whole truth; that the
 6 foregoing pages are a full, true, and accurate record of
 7 the proceedings, all done to the best of my skill and
 8 ability; that the proceedings were taken down by me in
 9 shorthand and thereafter reduced to print under my
 10 direction.

11 I CERTIFY that I am in no way related to, nor
 12 employed by any of the parties hereto, and have no
 13 interest in the outcome thereof.

14 [X] Review and signature was requested.
 15 [] Review and signature was waived.
 16 [] Review and signature not requested.

17 I CERTIFY that I have complied with the ethical
 18 obligations set forth in ACJA 7-206(F)(3) and ACJA
 19 7-206(J)(1)(g)(1) and (2). Dated at Prescott, Arizona,
 20 this 10th day of May, 2021.

Jill Marnell

21 _____
 22 JILL MARNELL
 23 Certified Reporter #50021
 24 Registered Professional Reporter

25 * * * * *

26 I CERTIFY that GLENNIE REPORTING SERVICES, LLC, has
 27 complied with the ethical obligations set forth in ACJA
 28 7-206(J)(1)(g)(1) through (6).

29 _____
 30 GLENNIE REPORTING SERVICES, LLC
 31 Registered Reporting Firm
 32 Arizona RRF No. R1035

EXHIBIT J

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,)
)
Plaintiff,)
)
vs.) 4:19-cv-00035
)
STATE OF ARIZONA; ARIZONA BOARD)
OF REGENTS, D/B/A UNIVERSITY OF)
ARIZONA, a governmental body of)
the State of Arizona; et al.,)
)
Defendants.)
)

VIDEOTAPED DEPOSITION OF MICHAEL MEISNER

Via Zoom videoconference
March 16, 2021
8:38 a.m.

Glennie Reporting Services, LLC
1555 East Oranewood Avenue
Phoenix, Arizona 85020

602.266.6535
www.glenne-reporting.com

Prepared by:

Jill Marnell, RPR
Arizona Certified
Reporter No. 50021

Michael Meisner, Videotaped - 03/16/2021

224

1 So are you on Tab 53?

2 A. Yes.

3 Q. Okay. And at the bottom of Tab 53 I'm just going
4 to read the Bates, AZSTATE.151009. Are you on that page?

5 A. 151099.

6 Q. Yes.

7 A. Yes.

8 Q. Okay. And what I want to refer you to is the
9 Footnote Number 1 that has the Website
10 www.cheatsheet.com/money-career -- I'm not going to read
11 the whole thing --

12 A. Right.

13 Q. Okay. If you could take a look at that. And
14 then on the share screen see if that appears to be the
15 same Website address and if that Website that's shown
16 there looks familiar to you.

17 A. It looks correct.

18 Q. Okay. So that, from your observation, is the
19 correct cheatsheet.com Website that you relied on in
20 building the chart that's in Tab 53, marked as [Exhibit 6](#)?

21 A. Yes.

22 Q. Okay. Can you read that first paragraph that's
23 on the screen there? Go ahead and read it out loud if you
24 can see it.

25 A. Oh. [As read]: More -- more employers than ever

Michael Meisner, Videotaped - 03/16/2021

225

1 are embracing health coverage for transgender employees,
2 as well as nondiscrimination protections. This is largely
3 a result of the proven low cost of providing transgender,
4 hyphen, inclusive care, comma, since transgender adults
5 represent just 0.3 percent of the US adult population.

6 Q. And is that the source for this chart where you
7 used the number that .3 percent of the adult population is
8 transgender in the United States?

9 A. Yes, this looks correct.

10 MR. CURTIS: Okay. Could I have Amanda
11 click on that link? It looks like a hyperlink, the
12 .3 percent of -- Yes. Could you click on that.

13 Q. BY MR. CURTIS: And Mr. Meisner, are you familiar
14 with cheatsheet.com? Is that something that you --

15 A. No --

16 Q. Okay.

17 A. -- I'm not. I don't regularly look at it or --
18 or subscribe or --

19 Q. And do you -- do you know if they conduct their
20 own research or if they just share sources from --
21 information from other sources?

22 A. Oh, I -- No, this -- they -- they share
23 information from other sources, from my understanding.

24 Q. Okay.

25 A. Yeah.

Michael Meisner, Videotaped - 03/16/2021

226

1 Q. So the link that was just clicked on while we
2 watched redirected us to another Website. Are you able to
3 read -- That looks pretty small for you --

4 A. Yeah.

5 Q. -- but are you able to read the Web address
6 there? Or at least the beginning so that we know the
7 source of that?

8 A. Maybe on this one. Sorry. Oh, shoot, the mouse
9 is on that so I can't see it here.

10 I think it -- I believe it says
11 pewresearch.org/fact -- and sorry --

12 Q. Okay.

13 A. -- I'm failing on my eye exam here.

14 Q. Okay. Wasn't that --

15 A. That's pew -- pew.org.

16 Q. Okay.

17 A. pewresearch.org.

18 Q. Yeah, it wasn't intended to be an eye test,
19 but --

20 A. Yeah.

21 Q. -- really to see what the ultimate source of the
22 data was that said --

23 A. Right.

24 Q. -- .3 percent of adults in the United States may
25 be transgender.

Michael Meisner, Videotaped - 03/16/2021

227

1 Do you recall when you did this research if
2 you would have followed a link like that?

3 A. Oh, absolutely. Yeah.

4 Q. And in your testimony earlier you made reference
5 to Pew. So is it your recollection that that figure
6 actually came from Pew Research?

7 A. Right, yes. It is my --

8 MR. CURTIS: Okay. I only have one more
9 link, if Amanda could click in that first paragraph. And
10 let me just read because it's probably easier for me.
11 About halfway through the paragraph [as read]: By one
12 reputable estimate, transgender adults represent about
13 .3 percent of the US adult population, and about
14 five percent of the adult lesbian, gay, bisexual,
15 transgender population identifies primarily as
16 transgender.

17 If -- Amanda, as you are driving, could you
18 click on that that says point -- above that, .3 percent of
19 the US adult population.

20 Q. BY MR. CURTIS: Do you -- do you recall if,
21 Mr. Meisner, if you had gone this far looking at some of
22 the results cited by Pew Research?

23 A. Yeah, so this is the study that I was talking
24 about. So this is --

25 Q. Are you able to see the Web address at the top of

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1 that or at least who the -- what the source is?

2 A. I'm sorry, I can't. If I moved I could, but I
3 can't see it from here. Sorry.

4 Q. Okay. I -- I could read it to you, but I -- I
5 don't know if you could verify just because I read it to
6 you.

7 A. Right.

8 Q. So I'll --

9 A. William Institute. I believe it says
10 williaminstitute.law, dot -- is that -- I'm sorry, I
11 can't -- I'm --

12 Q. Okay. My apologies to everyone for making this a
13 little bit tricky, not realizing that Mr. Meisner
14 wouldn't -- it is far on the screen --

15 A. I can't see.

16 Q. -- and it's very small print.

17 It's williamsinstitute.law@UCLA.edu and --

18 A. Okay.

19 Q. -- some additional --

20 But you do recall going that far and looking
21 at that study?

22 A. Right. And -- Yeah. So this is really -- You
23 know, we have the executive summary, the key findings, and
24 then I think there's some -- also their methodology is in
25 here as well.

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1 Q. Okay. So can you see there where it says "key
2 findings"?

3 A. Yes.

4 Q. Okay. And it also -- I'm going to just read the
5 first bullet. [As read]: An estimated 3.5 percent of
6 adults in the United States identify as gay -- excuse me,
7 identify as lesbian, gay or bisexual and an estimated
8 point -- 0.3 percent of adults are transgender.

9 Can you see that?

10 A. Yes.

11 Q. Okay. So just -- just to clarify, this is the
12 ultimate source of the data in the cheatsheet.com article
13 that you refer to in your chart?

14 A. Yes.

15 Q. But that research was not cheatsheet.com
16 research, it was rather from a Pew report; correct?

17 A. Yeah, it's from this -- from this and that, from
18 this report.

19 Q. Okay. So -- Yeah. So to connect the dots,
20 cheatsheet was citing the Pew report. And the Pew report
21 was citing what it claimed was a reputable, which was this
22 williamsinstitute.law@UCLA?

23 A. Yes.

24 MR. CURTIS: Okay. And with that I don't
25 have any other questions on redirect for Mr. Meisner,

1 STATE OF ARIZONA)
) ss.
 2 COUNTY OF YAVAPAI)

3 BE IT KNOWN that the foregoing proceedings were
 4 taken before me; that the witness before testifying was
 5 duly sworn by me to testify to the whole truth; that the
 6 foregoing pages are a full, true, and accurate record of
 7 the proceedings, all done to the best of my skill and
 8 ability; that the proceedings were taken down by me in
 9 shorthand and thereafter reduced to print under my
 10 direction.

11 I CERTIFY that I am in no way related to, nor
 12 employed by any of the parties hereto, and have no
 13 interest in the outcome thereof.

14 [X] Review and signature was requested.
 15 [] Review and signature was waived.
 16 [] Review and signature not requested.

17 I CERTIFY that I have complied with the ethical
 18 obligations set forth in ACJA 7-206(F)(3) and ACJA
 19 7-206(J)(1)(g)(1) and (2). Dated at Prescott, Arizona,
 20 this 30th day of March, 2021.

Jill Marnell

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 22 JILL MARNELL
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 27 complied with the ethical obligations set forth in ACJA
 28 7-206(J)(1)(g)(1) through (6).

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