Gender Affirming Surgery and Related Procedures

State(s):
- Idaho
- Montana
- Oregon
- Washington
- Other:

LOB(s):
- Commercial
- Medicare
- Medicaid

Enterprise Policy

BACKGROUND

The American Psychiatric Association’s Diagnostic and Statistical Manual, 5th Edition (DSM 5) defines criterion A of Gender Dysphoria as “a marked incongruence between one’s experience/expressed gender and assigned gender.” These individuals must meet additional criteria which include persistence over time and clinically significant distress or impairment in social, occupational or other important areas of functioning.

Benefits must be verified by reviewing the plan’s contract or plan document (PD). Some PacificSource benefit plans do not include coverage of gender affirming surgery, procedures or other related treatment. Groups may elect to customize these benefits; therefore, benefit determinations are based on specific contract language.

CRITERIA

The member should be placed into case management by Health Services as a way to help the member understand their benefits and required criteria related to gender affirming surgery and treatment, and to assist her/him to navigate the system and promote an optimal outcome.

Covered Services and Exclusions – Commercial, Medicaid

1. The following are considered medically necessary gender affirming surgeries.
   a. Core surgical procedures considered medically necessary for females transitioning to males include: hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, perineal electrolysis, and placement of testicular implant and mastectomy including nipple reconstruction.

   b. Core surgical procedures considered medically necessary for males transitioning to females include: penectomy, orchiectomy, vaginoplasty, clitoroplasty, perineal electrolysis, labiaplasty, and mammoplasty when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale or there is any contraindication to, or intolerance of, or patient refusal of hormone therapy.

2. The following procedures may be considered medically necessary surgeries for facial gender confirmation

   - Cheek augmentation
   - Electrolysis or laser hair reduction
   - Frontal bone reshaping
   - Brow Lift
   - Mandible bone reshaping
3. The following services to change specific appearance characteristics are considered not medically necessary when performed as part of gender affirmation procedures; this includes but is not limited to the following:

- Rhinoplasty
- Tracheal shaving

- Blepharoplasty
- Calf Implants
- Chemical peels
- Collagen/filler injections
- Dermabrasion
- Face-lift
- Forehead Lift
- Hair removal (e.g. electrolysis or laser) or hair transplantation (except when required pre-operatively for genital surgery or for facial gender confirmation)
- Liposuction- (may be medically necessary when associated with a mastectomy surgery)
- Lip reduction/augmentation
- Neck tightening
- Pectoral implants
- Removal of redundant skin (including abdominoplasty and panniculectomy)
- Silicone injections (e.g. for breast enlargement)
- Voice modification surgery or treatments
- Voice therapy lessons.

4. Gender-specific core services that may be medically necessary for transgender persons appropriate to their anatomy

   a. Breast cancer screening for female to male transgender persons who have not undergone a mastectomy;

   b. Prostate cancer screening for male to female transgender individuals who have retained their prostate.

5. In addition to core surgical procedures, specific plans may have benefits that include, but are not limited to: penile implants, and/or mammoplasty.

6. Gender affirming surgery benefits are limited to only one attempt at reconstruction (may be a multistage reconstructive procedure).

7. No coverage is provided for reversal of gender affirming surgery, whether or not that surgery was originally covered by their policy.

8. Gender affirming surgery conducted on infantile or early childhood intersexed individuals is a common medical practice and is not a contract exclusion.

Criteria for Eligibility and Readiness for Hormone Therapy – Commercial, Medicaid

Coverage for initial hormone therapy is available when the member has met all the following criteria and such coverage is available under the member’s policy:

1. Is at least 18 years old. Request for services for members under 18 years of age requires Pharmacist review.
a. Medicaid members must meet Medicaid criteria guideline note 127, Gender Dysphoria

2. Member has persistent, well-documented Gender Dysphoria.

3. Member has any significant medical or behavioral health concerns reasonably well-controlled.

4. Member has capacity to make a fully informed decision and to consent for treatment.

5. Licensed Mental Health Professional letter

   a. A licensed mental health professional (LMHP) has supplied a letter to the medical professional who will be responsible for the patient’s endocrine treatments addressing the following points:

      i. The patient’s general identifying characteristics;

      ii. The initial and evolving gender and any associated mental health concerns, and other psychiatric diagnoses;

      iii. The duration of the referring licensed mental health professional’s relationship with the client, including the type of evaluation and psychotherapy to date;

      iv. The clinical rationale for supporting the client’s request for hormone therapy and statement that the client meets eligibility criteria; and

      v. Permission to contact the licensed mental health professional for coordination of care, or

   a. As an alternative to the letter from LMHP:

      i. Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications.

      ii. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient’s age, previous experience with hormones, and concurrent physical or mental health concerns.

         The treating provider will obtain and document informed consent from the individual including the risks associated with hormone therapy (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers).

      iii. For members under 18 years of age, a letter from a LMHP will be required.

**Criteria for Gender Affirming Surgery Coverage – Commercial, Medicaid**

Gender affirming genital surgical procedures requires Medical Director review. Preauthorization is required for gender affirming surgical procedures.
Coverage for gender affirming surgery is available when all of the following criteria are met and such coverage is available under the member’s policy:

1. Member is at least 18 years old. Request for services for members under 18 years of age requires Medical Director review; and

2. Member has met criteria for the diagnosis of Gender Dysphoria, Post transition”; and

3. Member has met the criteria for hormonal therapy above; and

4. Member has capacity to make a fully informed decision and to consent for treatment; and

5. Condition is not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and

6. Member has any significant medical or behavioral health concerns reasonably well controlled; and

7. Member has completed all of the following in preparation for gender affirming surgery, either at a specialized gender dysphoria treatment center or under the direction of a Gender Dysphoria specialist:
   a. Member has had 12 continuous months of living in a gender role that is congruent with his/her gender identity unless a medical and licensed mental health professional both determine that this requirement is not safe for the patient; and
   b. Unless medically contraindicated, member has received at least 12 months of continuous hormonal gender affirming therapy recommended by a mental health professional and carried out by or under the supervision of an endocrinologist or comparably qualified specialist (which can be simultaneous with the real-life experience). Hormone therapy is not required for chest surgery in female-to-male members; and
   c. Recommendation for chest surgery or facial gender confirmation surgery must be made by one qualified, licensed mental health professionals who has experience in the evaluation of gender dysphoria with written documentation submitted to the physician performing the surgery.
   d. Recommendation for genital affirming surgery must be made by two qualified, licensed mental health professionals who have experience in the evaluation of gender dysphoria with written documentation submitted to the physician performing the surgery (where medically appropriate and given a well-established patient relationship, PacificSource may accept one of the two recommendations from a physician who has clinical experience with gender dysphoria even if not a licensed mental health professional).

I. Documentation must include a written comprehensive psychological evaluation second concurring opinion in the form of a written expert opinion. One of these letters must be within 6 months of the pre-service determination request.

II. The referring health professionals have supplied a letter to the medical professional who will be responsible for the patient’s surgical treatments addressing the following points:

1. The patient’s general identifying characteristics;
2. The initial and evolving gender and any associated mental health concerns, and other psychiatric diagnoses;

3. The duration of the referring health professional’s relationship with the client, including the type of evaluation and psychotherapy to date;

4. The clinical rationale for supporting the specific requested surgical procedures and a statement that the client meets eligibility criteria; and

5. Permission to contact the mental health professional for coordination of care.

Criteria for Facial Gender Confirmation Surgery Coverage – Commercial, Medicaid

Preauthorization is required for facial gender confirmation surgery. Gender affirming facial surgical procedures require Medical Director review.

A member who meets the following criteria may be considered for coverage of medically necessary and appropriate facial gender confirmation procedures:

1. Having a severe mental health comorbid condition that prevents the member from participating in community life due to experiencing or fear of experiencing physical violence based on marked facial gender non-congruence; and

2. Member receives medically necessary and appropriate non-surgical treatments for mental health comorbidity as recommended by the treatment team, and non-surgical treatments are determined to be insufficient to enable participation in community life; and

3. Member experienced a gender identity non-congruent hormonal puberty; and

4. Purpose of the surgery is to achieve a minimum level of facial gender congruence in order to be publicly identified as gender congruent and not solely to improve appearance; and

5. Facial gender confirmation surgery is necessary to achieve the benefits of the funded treatments for gender dysphoria: Mental health care, hormone therapy, and sex reassignment surgery also known as gender confirmation surgery; and

6. Member meets all the applicable requirements listed in the Criteria section for Gender Affirming Surgery Coverage above.

Post-Surgery Coverage and Continuation Hormone Therapy - Commercial, Medicaid

Once surgical gender affirming surgical procedure has been completed, hormone replacement therapy and medical treatment appropriate to the reassigned gender will be covered, as well as gender specific services that may be medically necessary for transgender persons appropriate to their anatomy. If a member has been on hormone therapy for 6 months or more prior to coming onto the plan and the plan does not include coverage for Gender Dysphoria, continuation of hormone therapy may be covered under supplemental benefits.

CODING INFORMATION

Diagnosis Codes (ICD-10):
F64.1 – Gender dysphoria in adolescence and adulthood
F64.2 – Gender dysphoria of childhood
F64.8 – Other dysphoria disorders
F64.9 – Gender dysphoria, unspecified
Z87.890 – Personal history of sex reassignment

CPT Codes covered when selection criteria are met:

11980  Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
17380  Electrolysis Epilation, Each 30 minutes (covered pre-operatively for genital surgery or for gender confirmation only)
17999  Unlisted procedure, Skin, mucous membrane (laser hair covered pre-operatively for genital surgery or for gender confirmation only)
19303  Mastectomy, simple, complete
19304  Mastectomy, subcutaneous
19324  Mammoplasty, augmentation; without prosthetic implant
19325  Mammoplasty, augmentation; with prosthetic implant
19350  Nipple/areola reconstruction
21120  Genioplasty; augmentation (autograft, allograft, prosthetic material) (for facial gender confirmation only)
21121  Genioplasty; sliding osteotomy, single piece (for facial gender confirmation only)
21123  Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) (covered for facial gender confirmation only)
21125  Augmentation, mandibular body or angle; prosthetic material (covered for facial Gender confirmation only)
21127  Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft) (covered for facial gender confirmation only)
21208  Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) (covered for facial gender confirmation only)
21209  Osteoplasty, facial bones; reduction (covered for facial gender confirmation only)
30400-30420  Rhinoplasty; primary (covered for facial gender confirmation only)
30430-30450  Rhinoplasty; secondary (covered for facial gender confirmation only)
31899  Unlisted procedure, trachea, bronchi (tracheal shaving for gender facial confirmation only)
53430  Urethroplasty, reconstruction of female urethra
54125  Amputation of penis; complete
54400-55417  Penile prosthesis
54520  Orchietomy, simple (including subcapsular), with or without testicular prosthesis, Scrotal or inguinal approach
54660  Insertion of testicular prosthesis (separate procedure)
54690  Laparoscopic, surgical; orchietomy
55175  Scrotoplasty; simple
55180  Scrotoplasty; complicated
55899  Unlisted surgery of the male genital system, for metoidioplasty and phalloplasty
55970  Intersex surgery; male to female
55980  Intersex surgery; female to male
56625  Vulvectomy simple; complete
56805  Clitoroplasty, intersex state
56810  Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
58150  Total Abdominal Hysterectomy (corpus and cervix with or without removal of tubes (s)
57106-57107;  Vaginectomy
57110-57111
57291-57292  Construction of artificial vagina
57335  Vaginoplasty, intersex state
58150, 58180;  Hysterectomy
58260; 58262;
58275-58291; 58541-58544; 58550-58554
58570-58573 Laparoscopy, surgical, with total hysterectomy
58661 Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy
58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral
67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach (covered for facial gender confirmation only)

CPT Codes considered not medically necessary as part of gender affirmation procedures:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>11950-11954</td>
<td>Subcutaneous injection of filling material (e.g., collagen)</td>
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<tr>
<td>15780-15787</td>
<td>Dermabrasion</td>
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<tr>
<td>15788-15789</td>
<td>Chemical Peel</td>
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<tr>
<td>15820-15823</td>
<td>Blepharoplasty</td>
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<tr>
<td>15824-15829</td>
<td>Rhytidectomy (face-lift)</td>
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<tr>
<td>15830-15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy, neck tightening); abdomen, infraumbilical panniculectomy</td>
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<tr>
<td>15876-15879</td>
<td>Suction assisted lipectomy (liposuction may be medically necessary when associated with mastectomy surgery)</td>
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<tr>
<td>17380</td>
<td>Electrolysis epilation, each 30 minutes (except for pre-operatively or facial gender confirmation)</td>
</tr>
<tr>
<td>21137-21139</td>
<td>Frontal Bone reshaping (forehead reduction and contouring)</td>
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<tr>
<td>40799</td>
<td>Unlisted procedure, lips (lip reduction/augmentation)</td>
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<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</td>
</tr>
<tr>
<td>92508</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals</td>
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Related Medical Policies

Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair

References

https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Care-for-Transgender-Adolescents

http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Health_Care_for_Transgender_Individuals

American Psychiatric Association’s Diagnostic and Statistical Manual, 5th edition (DSM-V)

Oregon Health Authority, Health System Division: Medical Assistance Programs chapter 410, Medicaid payment for behavioral health Services, Exception Criteria for Facial Gender Confirmation Surgery (FGCS) 410-172-0745. 5/2/2018, 2/11/2019

