Gender Affirming Surgery and Related Procedures

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon* ☐ *Washington*

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Gender affirming surgery and related procedures are possible treatments for individuals with gender dysphoria, which is distress or discomfort caused by a difference between a person's gender identity and their assigned sex at birth. These treatments may be a covered benefit for members with diagnoses of F64.0 through F64.9 (gender identity and dysphoria disorders), or Z87.890, personal history of sex reassignment.

PacificSource reviews for coverage in accordance with benefit plan language and established medical criteria. Some PacificSource benefit plans do not include coverage of gender affirming surgery and related procedures. Groups may elect to customize benefits; therefore, benefit determinations are based on contract language.

PacificSource gender affirming surgery and related procedures criteria follows Guideline Note 127 and Ancillary Guideline A4 of the Oregon Health Plan Prioritized List of Health Services and OAR 410-172-0745.

PacificSource Medicare follows CMS guidelines and criteria. National Coverage Determination (NCD) 140.9 and Local Coverage Determination (LCD) L35163 do not outline specific criteria and give direction for a case-by-case review. In absence of CMS criteria, PacificSource Medicare requests are reviewed on an individual basis for determination of coverage and medical necessity using this policy criteria.

Care Management services are available for members to assist with understanding benefits and criteria related to gender affirming surgery and treatment, and to provide support navigating gender affirming health care.

Criteria

The following coverage and criteria are based on the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 8.

Commercial, Medicaid and Medicare

I. Gender Affirming Treatment Coverage

A. Core Gender Affirmation

PacificSource may cover the following procedures:

- Clitoroplasty
- Hair removal (electrolysis or laser) as required pre-operatively on the surgical site or skin graft site
- Hysterectomy
- Labiaplasty
- Mammaplasty (with fat transfer/graft or implants)
- Mastectomy including nipple reconstruction and tattooing
- Metoidioplasty/ Meta
- Orchiectomy
- Penectomy
- Phalloplasty (may include penile implant)
- Placement of testicular implant
- Salpingo-oophorectomy
- Scrotoplasty
- Urethroplasty
- Vaginectomy
- Vaginoplasty

B. Facial Gender Confirmation

PacificSource may cover the following procedures:

- Brow lift/repair of brow ptosis
- Malar/Cheek augmentation, including reshaping, fat transfer/grafting (which may include liposuction), and implants
- Forehead lift
- Frontal bone reshaping/reduction
- Genioplasty/chin reconstruction
- Hair removal (electrolysis or laser)
- Lip lift
- Mandible (jaw) bone reshaping
- Rhinoplasty
- Tracheal shave (does not include laryngoplasty or laryngectomy)

C. Revisions

PacificSource only covers revisions to surgeries for the treatment of gender dysphoria in cases when the revision is required to address complications of the surgery (wound dehiscence, fistula, chronic pain directly related to the surgery, etc.). Revisions are not covered due to dissatisfaction with outcome.

D. Reversal

PacificSource does not cover reversal of a gender affirming surgery.

E. Non-Coverable Services

PacificSource does not cover services to improve gender specific appearance characteristics when performed as part of gender affirmation procedures. This includes, but is not limited to the following:

- Blepharoplasty and related procedures unless medically indicated. Refer to 'Blepharoplasty and Related Procedures' policy for more information.
- Body Contouring (fat transfer to hips or buttocks, liposuction to waist, hips, buttocks, or neck)
- Calf Implants or fat transfers
- Chemical peels
- Collagen/filler injections
- Dermabrasion
- Hair transplant
- Hair removal that is not required for facial confirmation or pre-operatively for gender affirming top/bottom surgeries
- Liposuction (may be medically necessary when associated with a mastectomy, breast augmentation, or malar/cheek augmentation)
- Lip reduction/augmentation (lip implants, injectable fillers)
- Laryngoplasty or laryngectomy
- Neck tightening procedures
- Pectoral implants or fat transfers
- Removal of redundant skin (including abdominoplasty and panniculectomy)
- Rhytidectomy/face-lift
- Silicone injections (e.g., for breast enlargement)
- Voice modification surgery or treatments

F. Adverse Benefit Determinations (Non-coverage)

All potential adverse benefit determinations (non-approvals) are reviewed and determined by a health care provider with experience prescribing or delivering gender affirming treatment.

II. Hormone Therapy

PacificSource Pharmacy Department reviews requests for hormone therapy for members under eighteen (18) years of age.

Prior authorization is not required for gender affirming hormone therapies for members 18 years of age and older.

III. Gender Affirming Surgery

A. Chest/Top and Genital/Bottom Surgical Procedures and Hair Removal for Adults

Prior authorization is required.

PacificSource considers chest/top and genital/bottom gender affirming procedures, including hair removal (electrolysis or laser), medically necessary when **ALL** of the following criteria is met:

1. A letter of recommendation (opinion) must be written within 12 months of the prior authorization request, by **one** qualified, licensed health care professional who has experience in the evaluation of gender dysphoria. Qualified Mental Health Provider (QMHP) letters are not eligible without licensed supervising provider's co-signature. The referring licensed health care professional's letter must include the clinical rationale for supporting the gender-affirming surgical procedure and address **ALL** of the following:
    a. Member is at least 18 years old;
    b. Member has a diagnosis of gender dysphoria;
    c. Duration of the referring health professional's relationship with the client, including the type of evaluation and treatment;
    d. Member's identifying characteristics and that they are established in their gender role;
    e. Member has capacity consent for treatment;
    f. Member understands the effect of gender-affirming surgery on reproduction and reproductive options have been explored. This can be addressed by any provider on the member's care team, including the surgeon;
    g. Other possible causes of apparent gender-incongruence have been identified and excluded;
    h. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgery have been assess, with risks and benefits discussed;
    i. Member has received at least 6 months of hormone treatment, or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated.
    j. Noted permission to contact the licensed health care professional for questions and coordination of care.
2. Request must include surgical pre-exam or consultation clinical notes, the clinical rationale for supporting the requested surgical procedures, and a statement that the member meets eligibility criteria. Clinical notes should also show evidence the member has been counseled on potential risks of treatment, complications, and post-surgical recovery and long-term care.
3. **PacificSource Community Solutions (Medicaid) Members**: Smoking cessation is required prior to **ALL** elective surgical procedures for active tobacco users. Cessation is required for at least 4 weeks prior to the procedure and requires objective evidence of abstinence from smoking prior to the procedure. Tests for confirmation of smoking cessation include cotinine levels and exhaled carbon monoxide testing. For members on nicotine replacement therapy (NRT) an alternative testing option is anabasine or anatabine testing.

B. Facial Gender Confirmation Surgery and Hair Removal for Adults

Prior authorization is required.

PacificSource considers facial gender confirmation surgery, including hair removal (electrolysis or laser), medically necessary when **ALL** of the following criteria is met:

1. A letter of recommendation (opinion) must be written within 12 months of the prior authorization request by **one** qualified, licensed health care professional who has experience in the evaluation of gender dysphoria with. Qualified Mental Health Provider (QMHP) letters are not eligible without licensed supervising provider's co-signature. The referring licensed health care professional's letter must include the clinical rationale for supporting the gender-affirming surgical procedure and address **ALL** of the following:
    a. Member is at least 18 years old;
    b. Member has a diagnosis of gender dysphoria
    c. Duration of the referring health professional's relationship with the client, including the type of evaluation and treatment;
    d. Member's identifying characteristics and that they are established in their gender role;
    e. Member has capacity to consent for treatment;
    f. Other possible causes of apparent gender-incongruence have been identified and excluded;
    g. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgery have been assess, with risks and benefits discussed;
    h. Member has received at least 6 months of hormone treatment, or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated;
    i. Member has a severe mental health comorbid condition that prevents them from participating in community life;
    j. Member receives medically necessary and appropriate non-surgical treatments for the mental health comorbidity as recommended by the treatment team, and non-surgical treatments are determined to be insufficient to enable participation in community life;
    k. Member experienced a gender identity non-congruent hormonal puberty;
    l. 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 to improve appearance;
    m. Facial gender confirmation surgery is necessary to achieve the benefits of the treatments for gender dysphoria: mental health care, hormone therapy, and gender confirmation surgery;
    n. Noted permission to contact the licensed health care professional for questions and coordination of care.
2. Request must include surgical pre-exam or consultation clinical notes, the clinical rationale for supporting the requested surgical procedures, and a statement that the member meets eligibility criteria. Clinical notes should also show evidence the member has been counseled on potential risks of treatment, complications, and post-surgical recovery and long-term care.
3. **PacificSource Community Solutions (Medicaid) Members**: Smoking cessation is required prior to **ALL** elective surgical procedures for active tobacco users. Cessation is required for at

least 4 weeks prior to the procedure and requires objective evidence of abstinence from smoking prior to the procedure. Tests for confirmation of smoking cessation include cotinine levels and exhaled carbon monoxide testing. For members on nicotine replacement therapy (NRT) an alternative testing option is anabasine or anatabine testing.

C. Gender Affirming Surgical Procedures for Adolescents

Prior authorization is required.

All gender affirming surgical treatment for adolescents requires MD review.

PacificSource considers gender confirmation surgery, including hair removal (electrolysis or laser), medically necessary when **ALL** of the following criteria is met:

1. Member has received a comprehensive biopsychosocial assessment including relevant mental health and medical professionals. This includes parent(s)/guardian(s) involvement in the assessment process unless the involvement is determined to be harmful to the adolescent or not feasible.
2. A letter of recommendation (opinion) must be written within 12 months of the prior authorization request for by **one** qualified, licensed health care professional who has experience in the evaluation of gender dysphoria with. Qualified Mental Health Provider (QMHP) letters are not eligible without licensed supervising provider's co-signature. The referring licensed health care professional's letter must include the clinical rationale for supporting the gender-affirming surgical procedure and address **ALL** of the following:
    a. The letter must reflect the comprehensive assessment and opinion from the treatment team that involves both medical and mental health professions;
    b. Member has a diagnosis of gender dysphoria;
    c. Duration of the referring health professional's relationship with the client, including the type of evaluation and treatment;
    d. Member's identifying characteristics and that they are established in their gender role;
    e. Member demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
    f. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender affirming medical treatment have been addressed; sufficiently so that gender affirming medical treatment can be provided optimally;
    g. Member has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility. This can be addressed by any provider on the member's care team;
    h. Member has had at least 12 months of gender affirming hormone therapy or longer, if required, to achieve the desired surgical result for the procedures, unless hormone therapy is either not desired or is medically contraindicated;
    i. Noted permission to contact the licensed health care professional for questions and coordination of care.
3. Request must include surgical pre-exam or consultation clinical notes, the clinical rationale for supporting the requested surgical procedures, and a statement that the member meets eligibility

criteria. Clinical notes should also show evidence the member has been counseled on potential risks of treatment, complications, and post-surgical recovery and long-term care.

IV. Voice Therapy

Prior authorization is required.

Voice therapy is covered within traditional therapies (PT/ST/OT) benefits. Please check the member's benefit plan for therapy benefit limits.

PacificSource considers gender affirming voice therapy medically necessary when a member has a documented diagnosis of gender dysphoria. Request for authorization should include documentation of a gender dysphoria diagnosis, as well as proposed evaluation and treatment plan.

Definitions

Abdominoplasty - Surgery to remove excess fat and skin from abdomen.

Blepharoplasty - Surgery to modify the eyelid.

Clitoroplasty - Surgery to create a clitoris.

Gender Dysphoria - A marked incongruence between one's experienced/expressed gender and assigned gender.

Genioplasty - Surgery to alter the chin.

Hysterectomy - Surgery to remove all or part of the uterus.

Labiaplasty - Surgery to alter the labia.

Laryngoplasty or laryngectomy - Surgery on the larynx (voice box) to alter one's voice.

Mammaplasty - Surgery to reconstruct or alter the breast.

Mastectomy - Surgery to remove one or both breasts.

Metoidioplasty - Surgery that works with existing genital tissue of individuals assigned female at birth to form a neophallus, or "new penis".

Orchiectomy - Surgery to remove of one or both testicles.

Panniculectomy - Surgery to remove excess fat and overhanging skin from abdomen.

Penectomy - Surgery to removal the penis.

Phalloplasty - Surgical procedures to construct a penis.

Rhinoplasty - Surgery that changes the shape of the nose.

Rhytidectomy - Surgical face lift.

Salpingo-oophorectomy - Surgery to remove one or both ovaries and fallopian tubes.

Scrotoplasty - Surgery that creates a scrotum.

Tracheal Shave - Surgery to reduce the size of the Adam's apple.

Urethroplasty - Plastic surgery of the urethra.

Vaginectomy - Surgery to remove all of part of the vagina.

Vaginoplasty - Surgery to create a vagina.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

The following CPT codes may be covered when the above criteria is met:

11920 Tattooing To Correct Color Defects; 6.0 Sq Cm/<

11921 Tattooing To Correct Color Defects; 6.1-20.0 Sq Cm

11922 Tattooing To Correct Color Defects; each Additional 20.0 Sq Cm

11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)

14060 Adjacent Tissue Transfer/Rearrangement, Eyelids/Nose/Ears/Lips; Defect 10 Sq Cm/<

14061 Adjacent Tissue Transfer/Rearrangement, Eyelids/Nose/Ears/Lips; Defect 10.1-30.0 Sq Cm

14301 Adjacent Tissue Transfer or Rearrangement, Any Area; Defect 30.1 Sq cm to 60.0 Sq cm

14302 Adjacent Tissue Transfer or Rearrangement, Any Area; Each Additional 30.0 Sq cm, or Part Thereof

15769 Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)

15770 Graft; Derma-Fat-Fascia

15771 Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arm 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)

17380	Electrolysis Epilation, Each 30 minutes (covered pre-operatively for gender affirming surgery or for facial gender confirmation only)
17999	Unlisted procedure, Skin, mucous membrane (laser hair covered pre-operatively for gender affirming surgery or for facial gender confirmation only)
19300	Mastectomy for gynecomastia
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece (for facial gender confirmation only)
21122	Genioplasty; Sliding Osteotomies, 2+ Osteotomies
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)
21137-21139	Frontal Bone reshaping (forehead reduction and contouring)
21172	Reconstruction Superior-Lateral Orbital Rim & Lower Forehead
21175	Reconstruction, Bifrontal, Superior-Lateral Orbital Rims & Lower Forehead
21188	Reconstruction, Midface, Osteotomies (Non-Lefort Type), W/Grafts, W/Obtaining Autografts
21193	Reconstruction, Mandibular Rami, Horizontal, Vertical, "C"/"L" Osteotomy; W/O Bone Graft
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21235	Graft; Ear Cartilage, Autogenous, Nose/Ear (Includes Obtaining Graft)
21270	Malar Augmentation, Prosthetic Matl
21295	Reduction, Masseter Muscle/Bone; Extraoral Approach30400-30420 Rhinoplasty; primary
30430-30450	Rhinoplasty; secondary

31750	Tracheoplasty; Cervical
31599	Unlisted Proc, Larynx
31899	Unlisted procedure, trachea, bronchi (tracheal shaving for gender facial confirmation)
40654	Repair Lip, Full Thickness; > One-Half Vertical Height/Complex
40799	Unlisted procedure, lips
53400	Urethroplasty; 1st Stage, Fistula/Diverticulum/Stricture
53405	Urethroplasty; 2nd Stage (Formation, Urethra), W/Urinary Diversion
53410	Urethroplasty, 1-Stage Reconstruction, Male Anterior Urethra
53415	Urethroplasty, Transpubic/Perineal, 1-Stage, Repair/Reconstruct, Prostatic/Membranous Urethra
53430	Urethroplasty, reconstruction of female urethra
53520	Closure, Urethrostomy/Urethrocutaneous Fistula, Male (Sep Proc)
54120	Amputation, Penis; Partial
54125	Amputation of penis; complete
54400-55417	Penile prosthesis
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, Scrotal or inguinal approach
54530	Orchiectomy, Radical, Tumor; Inguinal Approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopic, surgical; orchiectomy
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
56620	Vulvectomy Simple; Partial
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; 57110-57111	Vaginectomy
57291-57292	Construction of artificial vagina
57335	Vaginoplasty, intersex state
58150, 58180, 58260, 58262, 58275-58291, 58541-58544, 58550-58554	Hysterectomy
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)
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, two or more individuals

The following CPT codes considered <u>not coverable</u> as part of gender affirmation procedures:

11950-11954	Subcutaneous injection of filling material (e.g., collagen)
15780-15787	Dermabrasion
15788-15789	Chemical Peel
15820-15823	Blepharoplasty
15824-15829	Rhytidectomy (face-lift)

15830-15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy, neck tightening); abdomen, infraumbilical panniculectomy

15876-15879 Suction assisted lipectomy (liposuction may be medically necessary when associated with mastectomy surgery breast augmentation, or malar/cheek augmentation

17380 Electrolysis epilation, each 30 minutes (except for pre-operatively or facial gender confirmation)

S2900 Robot Surgical System

Related Policies

Blepharoplasty and Related Procedures

Care of the Surgical Patient

References

American College of Obstetricians and Gynecologists (ACOG). (March 2021). Health Care for Transgender and Gender Diverse Individuals: Committee Opinion, Number 823. Accessed March 16, 2022. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals

American Psychiatric Association. (2013) *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*.

The World Professional Association for Transgender Health (WPATH): Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, 2022 http://www.wpath.org

Appendix

Policy Number:

Effective: 4/16/2020 **Next review:** 4/1/2023

Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): Guideline Note 127 and Ancillary Guideline A4 of the Oregon Health Plan Prioritized List of Health Services, OAR 410-172-0745

Commercial OPs: 12/2022

Government OPs: 12/2022