Gender Affirming Surgery and Related Procedures

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

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 determination 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 reviewed for coverage in accordance with benefit plan language and established medical criteria. 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.

The American Psychiatric Association's Diagnostic and Statistical Manual, 5th Edition (DSM 5) definition of Gender Dysphoria as "a marked incongruence between one's experience/expressed gender and assigned gender" is used in addition to procedure specific guidelines to inform coverage determinations.

The member should be referred to Health Services case management team to help the member understand their benefits, required criteria related to gender affirming surgery and treatment, and to assist member to navigate the system to promote optimal outcomes.

Criteria

Commercial, Medicaid

1. Core gender affirming surgeries: the following are considered medically necessary procedures:
    - Hysterectomy
    - Vaginectomy
    - Salpingo-oophorectomy
    - Metoidioplasty
    - Phalloplasty (may include penile implant and hair removal of skin graft site)
    - Urethroplasty
    - Scrotoplasty
    - Perineal electrolysis/laser hair removal
    - Placement of testicular implant
    - Mastectomy including nipple reconstruction
    - Penectomy

- Orchiectomy
- Vaginoplasty
- Clitoroplasty
- Labiaplasty
- Mammoplasty (with fat transfer/graft or prosthetic implants) 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. Facial gender confirmation: All facial gender confirmation requests, including facial electrolysis/laser hair removal, requires MD review. The following procedures may be considered medically necessary procedures:

    - Cheek augmentation
    - Electrolysis or laser hair removal
    - Frontal bone reshaping
    - Brow Lift
    - Mandible bone reshaping
    - Rhinoplasty
    - Tracheal shaving (does not include laryngoplasty or laryngectomy)

3. Reconstruction: Revisions to surgeries for the treatment of gender dysphoria are only covered in cases where the revision is required to address complications of the surgery (wound dehiscence, fistula, chronic pain directly related to the surgery, etc.). Revisions solely for cosmetic issues are considered a policy exclusion and are not covered.

4. Reversal of a gender affirming surgery is not coverable.

5. Not medically necessary: 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:

    - Blepharoplasty
    - Calf Implants
    - Chemical peels
    - Collagen/filler injections
    - Dermabrasion
    - Face-lift
    - Fat transfer/grafting to lips, hips, face
    - Forehead Lift
    - Hair transplant
    - Hair removal (e.g. electrolysis or laser) (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
    - Laryngoplasty or laryngectomy
    - 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

Criteria for Hormonal Therapy

Commercial, Medicaid

PacificSource Pharmacy department reviews requests for hormone therapy for members under 18 years of age.

No prior authorization is required for members over 18 years old for gender affirming hormone therapies only.

See links below for additional medication authorization information:

https://communitysolutions.pacificsource.com/Search/Drug/Name

https://pacificsource.com/find-a-drug

Criteria for Gender Affirming Surgery Coverage

Commercial, Medicaid

Gender affirming surgery requires prior authorization and is coverable when **ALL** of the following criteria are met:

1. Member is **at least 18 years** old. **ALL** requests for services for members **under 18 years** of age require Medical Director review;

2. Member has met the diagnosis of Gender Dysphoria;

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

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

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

6. 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 gender identity unless a medical and licensed mental health professional both determine that this requirement is not safe for the patient;
    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;
    c. Chest/top surgery (mammoplasty or mastectomy) **additional requirements:**

- Recommendation for chest surgery (mammoplasty or mastectomy) must be made by **one** qualified, licensed mental health professionals who has experience in the evaluation of gender dysphoria.
- Letter of recommendation for chest surgery must be written within 12 months of the pre-service determination request.
- Documentation of 12 continuous months of hormonal (estrogen) therapy which 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.
- Documentation of surgical pre-exam by physician performing procedure

d. Hair removal (electrolysis or laser) for facial confirmation or bottom gender affirming procedures must meet all policy requirements for intended surgery, including surgical consultation /documentation in support of surgical plan (facial or bottom)

e. All facial confirmation procedures require MD review for any aged member and the following **additional requirements**:

- Recommendation 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.
- Letter of recommendation must be written within 12 months of the pre-service determination request.

f. Genital/bottom gender affirming procedures:

- Medical Director review is required for **ALL** gender affirming genital surgical procedure requests for members who are under 18 years of age.
- Recommendation for genital (bottom surgeries, including hysterectomy) 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).
- 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 12 months of the pre-service determination request.
- The referring health professionals have supplied a letter to the medical professional who will be responsible for the patient's surgical treatments addressing **ALL** of 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 health professional's relationship with the client, including the type of evaluation and psychotherapy to date;
    iv. The clinical rationale for supporting the specific requested surgical procedures and a statement that the client meets eligibility criteria: **and**
    v. Permission to contact the mental health professional for coordination of care.

Criteria for Facial Gender Confirmation Surgery Coverage

Commercial, Medicaid

Prior authorization is required

All facial gender confirmation surgery requires *Medical Director review and may be covered when* **ALL** of the following criteria are met:

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;
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;
3. Member experienced a gender identity non-congruent hormonal puberty;
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;
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;
6. Member meets all the applicable requirements listed in the Criteria section for Gender Affirming Surgery Coverage above; and
7. Requests for facial electrolysis only must meet all facial confirmation surgery criteria as above.

Additional Criteria for PacificSource Community Solutions Members only

1. Member meets all the applicable requirements in Guideline Note 127, Gender Dysphoria of the Prioritized List in subsections (a, b, and d) for cross-sex hormone therapy and subsection (f) for sex reassignment surgery, also known as gender confirmation surgery, as referenced in OAR 410-141-3830.
2. All other conditions of OAR 410-141-3820 (11) are met.
3. The surgery is medically necessary and appropriate as defined in 410-120-0000.
4. Smoking cessation is required prior to 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.

Medicaid

PacificSource Community Solutions follows Guideline Note 127 & Ancillary Guideline A4 of the OHP Prioritized List of Health Services for coverage of Gender Affirming Surgery.

Medicare

PacificSource Medicare follows National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9)

The Centers for Medicare & Medicaid Coverage (CMS) conducted a National Coverage Analysis that focused on the topic of gender reassignment surgery. Effective August 30, 2016, after examining the

medical evidence, CMS determined that no national coverage determination (NCD) is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with gender dysphoria. In the absence of an NCD, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

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)
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis,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 genital surgery or for gender confirmation only)
17999	Unlisted procedure, Skin, mucous membrane (laser hair covered pre-operatively for genital 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) (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	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, Scrotal or 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
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 and 57110-57111	Vaginectomy
57291-57292	Construction of artificial vagina
57335	Vaginoplasty, intersex state
58150, 58180, 58260, 58262, 58275-58291, 58541-58544, and	Hysterectomy

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:

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)
17380	Electrolysis epilation, each 30 minutes (except for pre-operatively or facial gender confirmation)
21137-21139	Frontal Bone reshaping (forehead reduction and contouring)
40799	Unlisted procedure, lips (lip reduction/augmentation)
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

Related Policies

Care of the Surgical Patient

Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair

References

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The World Professional Association for Transgender Health (WPATH): (formerly Harry Benjamin International Gender Dysphoria Association) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version, 2011, Accessed 03/18/2020 http://www.wpath.org

Appendix

Policy Number: [Policy Number]

Effective: 4/16/2020 **Next review:** 4/1/2022

Policy type: Enterprise

Author(s): Kimberly Pittman; Polly Watt-Geier

Depts: Health Services

Applicable regulation(s):

Commercial Ops: 5/2021