Medical Policy: Gender Affirming/Reassignment Surgery — Connecticut (Commercial/Medicare)

POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
MG.MM.SU.28mC23	**05/13/2022**	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Definitions

Gender dysphoria	General descriptive term that refers to an individual's discontent with the assigned gender. It is more specifically defined when used as a diagnosis. See APPENDIX to view complete DSM V Gender Dysphoria definition
Transgender	Refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their gender at birth.
Transsexual	Refers to an individual who seeks, or has undergone, a social transition from male to female or female to male. In many, but not all, cases this also involves a physical transition through cross-sex hormone treatment and genital surgery (sex reassignment surgery).
Hormonal gender reassignment	The administration of androgens to genotypic and phenotypic females and estrogen or progesterones to genotypic or phenotypic males for the purpose of effecting somatic changes to more closely approximate the physical appearance of the genotypically other sex.[1] Hormones are also utilized for pubertal suppression.
Genital surgical gender reassignment	Genital surgery that alters the morphology to approximate the physical appearance of the genetically other sex. The surgical procedures in the table below (occurring in the absence of any diagnosable birth defect or other medically defined pathology [except gender dysphoria]) are included in this category.

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Gender non-conforming (TGNC-Transgender/Gender Non-Conforming)	Also referred to as non-binary. Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.
Non-binary	The individual's identity does not exist as a dichotomy of male or female (binary) but rather identifies as belonging to neither male nor female genders and prefer pronouns such as they and them, and possibly label themselves as Gender Non- Conforming.

Common Medically Necessary Procedures	
Breast augmentation*	Phalloplasty ±
Breast reduction mammaplasty (trial of Hormone therapy not pre-requisite)	Prostatectomy
	Salpingectomy
Clitoroplasty	Scrotoplasty
Hysterectomy	Testicular/penile prosthesis Implantation
Labioplasty	Urethroplasty
Mastectomy (trial of hormone therapy not pre- requisite)	Vaginectomy
Metoidioplasty	Vaginoplasty ±
Oophorectomy	Vulvectomy
Orchiectomy	Vulvoplasty
Penectomy	

* Breast augmentation is considered medically necessary provided that the member has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the member is otherwise unable to take hormones

± Genital electrolysis is not considered a surgical procedure, but is performed in conjunction with genital surgery (i.e., when required for vaginoplasty or phalloplasty)

[1] Hormonal gender reassignment does not refer to the administration of hormones for the purpose of medical care or research conducted for the treatment or study of non–gender-dysphoric medical conditions (i.e., aplastic anemia, impotence, cancer).

Guideline

A. Hormone therapy (whether or not in preparation for gender affirming/reassignment surgery) will be covered as follows:

1. Treatment with gonadotropin-releasing hormone agents (pubertal suppressants) when based upon a determination by a qualified medical professional that the member is eligible and ready for such treatment, i.e., that the member:
    a. Meets gender dysphoria diagnostic criteria
    b. Has experienced puberty to at least Tanner stage 2 with pubertal changes resulting in increased gender dysphoria

c. Does not suffer from psychiatric comorbidity that interferes with diagnostic work-up or treatment

d. Has adequate psychological and social support during treatment

e. Demonstrates knowledge and understanding of expected treatment-outcomes associated with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment

2. Treatment with cross-sex hormones, including testosterone, cypionate, conjugated estrogen, and estradiol, for members **greater than or equal to 16** years of age, when based upon a determination of medical necessity made by a qualified medical professional. (Members less than 18 years of age must meet Criteria # 1).

Note: Requests for coverage of cross-sex hormones for members less than 16 years of age will be reviewed on a case-by- case basis

B. Gender affirming/reassignment surgery will be covered for members **greater than or equal to** 18 years of age.

The request must be accompanied by letters from two qualified Connecticut State (CTS) licensed health professionals, acting within the scope of his/her practice, who have independently assessed the member and are referring the member for the surgery. (Note: Only one letter is required for breast surgery)

One letter must be from a psychiatrist, psychologist, psychiatric nurse practitioner (NP) or licensed clinical social worker (CSW) with whom the member has an established and ongoing relationship.

The other letter may be from a psychiatrist, psychologist, physician, psychiatric NP or licensed CSW who has only an evaluative role with the member.

Together, the letters must establish that the member:

1. Has a persistent and well-documented case of gender dysphoria
2. Has received hormone therapy (not prerequisite for mastectomy) appropriate to member's gender goals for a minimum of 12 months prior to seeking genital surgery (unless medically contraindicated or the member is otherwise unable to take hormones)
3. Has lived 12 months in gender role congruent with member's gender identity (inclusive of binary and Nonbinary Gender) and has received mental health counseling, as deemed medically necessary, during that time (Note: Not required for breast surgery)
4. Has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so that those are reasonably well-controlled prior to the gender reassignment surgery
5. Has the capacity to make fully informed decisions and consent to treatment

Limitations/Exclusions

A. Requests for gender reassignment surgery for members less than 18 years will be reviewed on a case-by-case basis.

B. The following services and procedures are excluded from coverage:
1. Cryopreservation, storage, and thawing of reproductive tissue (including all related services and charges)
2. Reversal of genital and/or breast surgery
3. Reversal of surgery to revise secondary sex characteristics
4. Reversal of any procedure resulting in sterilization

C. Coverage is not available for any surgeries, services or procedures that are purely cosmetic (i.e., when performed solely to enhance appearance, but not to medically treat the underlying gender dysphoria).

The following surgery, services and procedures will be reviewed on a case by case basis. It is expected that the clinical rationale for each requested procedure is specifically documented in the letter of medical necessity from the treating physician:

1. Abdominoplasty, blepharoplasty, neck tightening or removal of redundant skin
2. Breast, brow, face or forehead lifts
3. Calf, cheek, chin, nose or pectoral implants Collagen injections
4. Drugs to promote hair growth or loss
5. Gluteal augmentation
6. Electrolysis (unless required for vaginoplasty or phalloplasty)
7. Facial bone reconstruction, reduction, or sculpturing (including jaw shortening) and rhinoplasty
8. Hair transplantation
9. Lip reduction
10. Liposuction
11. Thyroid chondroplasty
12. Voice therapy, voice lessons or voice modification surgery

Applicable Diagnosis Codes

F64.0	Transsexualism
F64.1	Gender Dysphoria (ICD 10 Code Diagnosis: Dual-Role Transvestism)
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Applicable Procedure Codes

11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
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
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
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
55150	Resection of scrotum
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)
55810	Prostatectomy, perineal radical;
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal
55840	Prostatectomy, retropubic radical, with or without nerve sparing;

55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56620	Vulvectomy simple; partial
55625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57106	Vaginectomy, partial removal of vaginal wall
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy, complete removal of vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
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)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
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)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
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

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Revision History

DATE	REVISION
11/12/2021	Added the following CPT codes as medically necessary services: 11920, 11921, 11922, and 19350
11/03/2020	Added gluteal augmentation to case-by-case review list
05/08/2020	Specific to breast surgery: 1. Eliminated two-letter prerequisite 2. Eliminated prerequisite requiring members to live 12 months in the gender congruent with the member's gender identity
12/01/2019	Connecticare has adopted the clinical criteria of its parent corporation, EmblemHealth. Retired CCI policy Gender Reassignment Surgery Reformatted and reorganized policy, transferred content to new template