

Medical Policy: Gender Affirming/Reassignment Surgery (Commercial)



POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
MG.MM.SU.28m	05/08/2020	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. 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).

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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.
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 mammoplasty (trial of hormone therapy not pre-requisite)	Prostatectomy
Clitoroplasty	Salpingectomy
Hysterectomy	Scrotoplasty
Labioplasty	Testicular/penile prosthesis Implantation
Mastectomy (trial of hormone therapy not pre- requisite)	Urethroplasty
Metoidioplasty	Vaginectomy
Oophorectomy	Vaginoplasty ±
Orchiectomy	Vulvectomy
Penectomy	Vulvoplasty

* 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).

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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)

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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. Electrolysis (unless required for vaginoplasty or phalloplasty)
6. Facial bone reconstruction, reduction or sculpturing (including jaw shortening) and rhinoplasty
7. Hair transplantation
8. Lip reduction
9. Liposuction
10. Thyroid chondroplasty
11. Voice therapy, voice lessons or voice modification surgery

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Applicable Coding

To access the codes, please download the policy **to your computer, and click on the paperclip icon within the policy**



Applicable CPT and Diagnosis Codes

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Yarbrough, E. *Transgender Mental Health*. 2018, American Psychiatric Association.

Revision history

DATE	REVISION
05/08/2020	Specific to breast surgery: <ul style="list-style-type: none">1. Eliminated two-letter prerequisite2. Eliminated prerequisite requiring members to live 12 months in the gender congruent with the member's gender identity
12/01/2019	<ul style="list-style-type: none">Connecticare has adopted the clinical criteria of its parent corporation, EmblemHealth. Retired CCI policy Gender Reassignment SurgeryReformatted and reorganized policy, transferred content to new template