Clinical Review Criteria Related to Gender Reassignment Surgery

☐ Corporate ☒ FF ☒ SF ☒ Medicare ☐ MedSupp-G ☐ MedSupp-I ☒ Medicaid ☐ TPA

Definitions:

Gender dysphoria (GD) is a condition in which there is a marked incongruence between an individual's physical or assigned gender and the gender with which the individual identifies for at least 6 months. Individuals with gender dysphoria may be very uncomfortable with the gender they were assigned at birth. Gender dysphoria may cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender reassignment surgery may also be referred to as gender-affirming or gender-confirmation surgery which is part of a treatment plan for gender identity dysphoria. Surgery includes the surgical procedures by which one's physical appearance and function of a person's existing sexual characteristics are changed to those of the other sex in an effort to improve their quality of life.

Policy:

Medical Criteria Disclaimer

Property of Health New England. All rights reserved. The treating physician or primary care provider must submit to Health New England the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Health New England will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how Health New England determines whether certain services or supplies are medically necessary. Health New England 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). Health New England expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program 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 Health New England, as some programs exclude coverage for services or supplies that Health New England considers medically necessary. If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage and Medicaid members. Health New England has adopted the herein policy in providing management, administrative and other services to its Health Plan.

I. Criteria for Approval

A. Gender Reassignment Surgery (GRS) may be considered medically necessary when ALL the following criteria are met:

1. The member is at least 18 years of age, and

2. The member has been diagnosed with gender identity disorder, and

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3. The new gender identity has been present for at least twenty-four months, and

4. The member has undergone a minimum of twelve months of continuous hormonal therapy and/or puberty blockers under the supervision of a physician and the physician reports medication compliance. There is no hormonal therapy requirement for mastectomy only.

5. Member has lived as their reassigned gender full time for 12 months or more.

6. Member's medical and mental health providers document that there are no contraindications for the planned surgery and agree with the plan.

7. If the member has a significant mental health issue such as impaired reality testing, bipolar disorder, dissociative disorder and borderline personality disorder, an effort must be made to improve the condition with psychotropic medications and/or psychotherapy before surgery is contemplated.

II. Required Documentation:

A. A letter of medical necessity from the member's medical and behavioral health providers who have had an evaluative role with the member. The letter must include the following:

1. Gender-identifying characteristics, psychosocial assessment

2. Initial and evolving gender, sexual and other psychiatric diagnoses

3. Confirmed diagnosis of gender dysphoria that meets applicable DSM5 criteria

4. Compliance with prescribed treatments (i.e., hormone therapy) and likelihood of future compliance

5. Confirmation that the member has completed twelve months of continuous, full time life experience living in a gender role that is congruent with member's gender dysphoria. This process assists in confirming the member's ability to function in this role long-term, as well as the adequacy of his/her support system. During this time period, the member would be expected to maintain their baseline functional lifestyle with work or school and participate in community activities.

6. If any significant coexisting mental health or medical concerns are identified prior to surgery, medical documentation is required to ensure conditions are being optimally managed and are reasonably controlled.

7. A mental health screening and/or assessment is needed for referral to hormonal and surgical treatments for gender dysphoria. Psychotherapy is highly recommended but is not a requirement.

8. One written letter of assessment for Top Surgery needs to be completed by a psychiatrist or licensed mental health professional.

9. Two written letters from qualified mental health professionals are needed for Bottom Surgery. Two separate letters or one that can be signed by both professionals is needed. There needs to be an assessment from the member's behavioral health therapist who has

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performed the initial evaluation. The second assessment should be from a person who has only had an evaluative role with the member.

B. A letter from the treating surgeon attesting that the member meets criteria outlined in this policy. The surgeon should have a demonstrated competency and extensive training in sexual reconstructive surgery.

   1. The surgeon believes the member is likely to benefit from surgery.

   2. The surgeon has communicated with the treating physician and the treating behavioral health provider.

   3. The surgeon has communicated with the member and that the member understands

      a. The required length of hospitalization(s)
      b. Possible complications
      c. Post-surgical rehabilitation requirements
      d. The surgeon has personally communicated with the member all the available different surgical techniques and the advantages and disadvantages of the procedure including risks and complications.
      e. The preservation of fertility or sterility has been discussed.

III. Covered Procedures:

CPT®* Codes	**Description**
55970†	**Intersex surgery; male to female**
† Includes only the following procedures:	
17380	Electrolysis epilation, each 30 minutes
19316	Mastopexy
19325	Mammoplasty, augmentation; with prosthetic implant
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19380	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
54120	Amputation of penis; partial
54125	Amputation of penis; complete

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54300	Plastic operation of penis for straightening of chordee (e.g., hypospadias), with or without mobilization of urethra
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty complicated
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
89259	Cryopreservation; sperm
89343	Storage, (per year); sperm/semen

Cheek Augmentation	Code Description
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21270	Malar augmentation, prosthetic material

Jaw Reconstruction	Code Description
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

Chin Reconstruction	Code Description
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction

Face Lift	Code Description
15824 Facial Feminization	Rhytidectomy; forehead
15825 Facial Feminization	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)

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15826 Facial Feminization	Rhytidectomy; glabellar frown lines
15828 Facial Feminization	Rhytidectomy; cheek, chin, and neck

Liposuction	**Code Description**
15876 Facial Feminization	Suction assisted lipectomy; head and neck

Trachea Shave	**Code Description**
31599	Unlisted procedure, larynx

Brow Reconstruction CPT codes	**Code Description**
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid ;with excessive skin weight of lid
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Rhinoplasty CPT codes	**Code Description**
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21270	Malar augmentation, prosthetic material
21299	Unlisted craniofacial and maxillofacial procedure
21499	Unlisted musculoskeletal procedure, head
30400	Rhinoplasty, primary; lateral and alar cartilages and or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair

CPT®* Codes	**Description**
55980†	**Intersex surgery, female to male**
† Includes only the following procedures:	
15820	Blepharoplasty, lower eyelid

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15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid ;with excessive skin weight of lid
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Mammoplasty, augmentation; with prosthetic implant
19328	Removal of intact breast
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap
19364	with free flap (e.g., fTRAM, DIEP, SIEA, GAP flap)
19367	with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap uni25B2
19368	with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction
19396	Preparation of Moulage for custom breast implant
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)

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21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21270	Malar augmentation, prosthetic material
21299	Unlisted craniofacial and maxillofacial procedure
21499	Unlisted musculoskeletal procedure, head
30400	Rhinoplasty, primary; lateral and alar cartilages and or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
53430	Urethroplasty, reconstruction of female urethra
54400	Insertion of penile prosthesis; 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
54406	Removal of all components of a multi-component inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component (s) of a multi-component, inflatable penile prosthesis
54415	Removable of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis without replacement of prosthesis
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
54660	Insertion of testicular prosthesis

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55899	Unlisted procedure, male genital system Metoidioplasty procedure
56620	Vulvectomy; simple
56625	Vulvectomy; complete
56810	Perineoplasty, repair of perineum, nonobstetrical
57110	Vaginectomy, complete removal of vaginal wall
57111	Vaginectomy; with removal of paravaginal tissue (radical vaginectomy)
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 gms or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
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)
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;

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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)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
89337	Cryopreservation; mature oocyte (s)
89346	Storage, (per year); oocytes

A. **Facial feminization** may be considered **MEDICALLY NECESSARY** when ALL of the required documentation is received and meets the criteria for gender reassignment surgery.

**** MEDICARE does not cover facial feminization procedures.**

B. **Cryopreservation of eggs or sperm** (including retrieval and up to one year of storage) will be covered for members undergoing gender reassignment treatment when documentation confirms a member with GD will be undergoing this treatment which is likely to result in infertility. Health New England, however, does not cover any costs associated with any form of Surrogacy including gestational carriers.

**** MASS HEALTH does NOT cover cryopreservation and storage fees.**

C. **Electrolysis and/or laser ablation treatments** may be **MEDICALLY NECESSARY** for hair removal performed by a licensed qualified treating provider when it is part of the standard pre-operative preparation for genital affirming/genital reconstruction/affirmation surgery.

D. **More than one breast augmentation is considered not medically necessary. This does not include the medically necessary replacement of breast implants.**

IV. What is Not Covered:

A. Cosmetic procedures to enhance physical appearance:

1. abdominoplasty
2. calf implants
3. collagen injections, botox

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4. hair transplantation (drugs)
5. electrolysis (except for genital reconstruction surgery as noted above)
6. lip reduction/enhancement
7. lipofilling/suction assisted lipoplasty, liposuction (except related to facial feminization)
8. body contouring procedures
9. pectoral implants
10. removal of redundant skin
11. skin resurfacing (e.g., dermabrasion, chemical peels)
12. voice modification surgery (vocal cord surgery)
13. voice therapy/voice lessons
14. gender reversal surgery
15. travel and lodging expenses
16. Reconstructive surgery following gender affirmation surgery to reverse natural signs of aging or if unsatisfied with surgical results

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