



Gender Affirming Surgery and Related Procedures

State(s):

Idaho Montana Oregon Washington Other:

LOB(s):

Commercial Medicare Medicaid PSA

Commercial Policy

BACKGROUND

The American Psychiatric Association's Diagnostic and Statistical Manual, 5th Edition (DSM 5) defines criterion A of Gender Dysphoria as "a marked incongruence between one's experience/expressed gender and assigned gender." These individuals must meet additional criteria which include persistence over time and clinically significant distress or impairment in social, occupational or other important areas of functioning.

According to DSM 5, some individuals who meet criteria for Gender Dysphoria may also identify as being transsexual in that they "seek or have undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and gender affirming surgery."

Benefits must be verified by reviewing the plan's contract or plan document (PD). 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.

CRITERIA

The member should be placed into case management by Health Services as a way to help the member understand their benefits and required criteria related to gender affirming surgery and treatment, and to assist her/him to navigate the system and promote an optimal outcome.

Exclusions and Covered Services

1. The following are considered medically necessary gender affirming surgeries.
 - a. Core surgical procedures considered medically necessary for females transitioning to males include: hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular implant and mastectomy including nipple reconstruction.
 - b. Core surgical procedures considered medically necessary for males transitioning to females include: penectomy, orchiectomy, vaginoplasty, clitoroplasty, perineal electrolysis, labiaplasty, and mammoplasty 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. The following 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:

- Calf Implants
- Cheek/malar implants
- Chin/nose implants
- Collagen/filler injections
- Face-lift
- Facial bone reduction/remodeling
- Forehead Lift
- Hair removal (e.g. electrolysis or laser)
- Liposuction- may be medically necessary when associated with a mastectomy surgery
- Lip reduction/augmentation
- Neck tightening
- Pectoral implants
- Reduction thyroid chondroplasty
- Voice modification surgery or treatments
- Voice therapy lessons.

3. PacificSource has policy coverage guidelines for the following procedures. These procedures are considered not medically necessary when the policy criteria are not met or are not covered when the policy has a specific exclusion

- Abdominoplasty – see coverage guideline MCG A-0497
- Blepharoplasty –PacificSource policy Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair
- Brow lift –PacificSource policy Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair
- Mandibular osteotomy – see coverage guideline MCG A-0247
- Panniculectomy – see coverage guideline MCG A-0498
- Rhinoplasty – see coverage guideline MCG A-0184

4. Gender-specific core services that may be medically necessary for transgender persons appropriate to their anatomy

- a. Breast cancer screening for female to male transgender persons who have not undergone a mastectomy;
- b. Prostate cancer screening for male to female transgender individuals who have retained their prostate.

5. In addition to core surgical procedures, specific plans may have benefits that include, but are not limited to: penile implants, mammoplasty, and/or travel benefits (refer to the GID travel benefit procedure). For Commercial plan in Oregon (fully insured and self-insured subject to the Oregon Insurance Code), these additional services are reviewed for approval or denial based on medical necessity.

6. Gender affirming surgery benefits are limited to only one attempt at reconstruction (may be a multistage reconstructive procedure).

7. No coverage is provided for reversal of gender affirming surgery, whether or not that surgery was originally covered by their policy.

8. Gender affirming surgery conducted on infantile or early childhood intersexed individuals is a common medical practice and is not a contract exclusion.

Criteria for Eligibility and Readiness for Hormone Therapy – Commercial, PSA

Coverage for initial hormone therapy is available when the member has met all the following criteria and such coverage is available under the member's policy:

1. Is at least 18 years old. Request for services for members under 18 years of age requires Medical Director review.
2. Member has persistent, well-documented Gender Dysphoria.
3. Member has any significant medical or behavioral health concerns reasonably well-controlled.
4. Member has capacity to make a fully informed decision and to consent for treatment.
5.
 - a. A licensed mental health professional (LMHP) has supplied a letter to the medical professional who will be responsible for the patient's endocrine treatments addressing 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 licensed mental health professional's relationship with the client, including the type of evaluation and psychotherapy to date;
 - iv. The clinical rationale for supporting the client's request for hormone therapy and statement that the client meets eligibility criteria; and
 - v. Permission to contact the licensed mental health professional for coordination of care, or
 - b. As an alternative to the letter from LMHP:
 - i. Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications.
 - ii. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

The treating provider will obtain and document informed consent from the individual including the risks associated with hormone therapy (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers).
 - iii. For members under 18 years of age, a letter from a LMHP will be required.

Criteria for Gender Affirming Surgery Coverage – Commercial, PSA

Gender affirming *genital* surgical procedures requires Medical Director review.

Preauthorization is required for gender affirming surgical procedures.

Coverage for gender affirming surgery is available when all of the following criteria are met as such coverage is available under the member's policy:

1. Member is at least 18 years old. Request for services for members under 18 years of age requires Medical Director review; and
2. Member has met criteria for the diagnosis of Gender Dysphoria, Post transition”; and
3. Member has met the criteria for hormonal therapy above; and
4. Member has capacity to make a fully informed decision and to consent for treatment; and
5. Condition is not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
6. Member has any significant medical or behavioral health concerns reasonably well controlled;
7. 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 his/her gender identity unless a medical and licensed mental health professional both determine that this requirement is not safe for the patient; and
 - 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; and
 - c. Recommendation for chest 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.
 - d. Recommendation for genital 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).
 - I. 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 6 months of the pre-service determination request.
 - II. The referring health professionals have supplied a letter to the medical professional who will be responsible for the patient’s surgical treatments addressing the following points:
 - III.
 1. The patient’s general identifying characteristics;
 2. The initial and evolving gender and any associated mental health concerns, and other psychiatric diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and psychotherapy to date;
4. The clinical rationale for supporting the specific requested surgical procedures and a statement that the client meets eligibility criteria; and
5. Permission to contact the mental health professional for coordination of care.

Post-Surgery Coverage and Continuation Hormone Therapy

Once surgical gender affirming surgical procedure has been completed, hormone replacement therapy and medical treatment appropriate to the reassigned gender will be covered, as well as gender specific services that may be medically necessary for transgender persons appropriate to their anatomy. If a member has been on hormone therapy for 6 months or more prior to coming onto the plan and the plan does not include coverage for Gender Dysphoria, continuation of hormone therapy may be covered under supplemental benefits.

CODING INFORMATION

Diagnosis Codes (ICD-9):

302.6 Gender Identity Disorder in Children

302.85 Gender Identity Disorder in Adolescents or Adults

Diagnosis Codes (ICD-10):

F64.1 – Gender identity disorder in adolescence and adulthood

F64.2 – Gender identity disorder of childhood

F64.8 – Other gender identity disorders

F64.9 – Gender identity disorder, unspecified

Z87.890 – Personal history of sex reassignment

CPT Codes:

55970 Intersex surgery; male to female

55980 Intersex surgery; female to male

Related Medical Policies

Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair

References

American College of Obstetricians and Gynecologists (ACOG). Care for Transgender Adolescents> Committee Opinion. Number 685, January 2017.

<https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Care-for-Transgender-Adolescents>

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<http://www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf>

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Smith YL, Van Goozen SH, Kuiper AJ, Cohen-Kettenis PT. Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychol Med*. 2005; 35(1):89-99
Accessed 11/27/2017. <https://www.ncbi.nlm.nih.gov/pubmed/15842032>

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, <http://www.wpath.org>