

MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL

POLICY TITLE: Gender Affirmation Surgery

POLICY STATEMENT: Gender affirmation surgery is one treatment option for extreme cases of Gender Dysphoria Disorder. Gender dysphoria disorder (formerly termed gender identity disorder) is defined as persistent cross-gender identification. Persons with this disorder experience a sense of discomfort and inappropriateness relating to their anatomic/genetic sexual characteristics. Hormonal gender affirmation refers to the administration of androgens to genetic females or alternatively, estrogen and/or progesterone to genetic males in order to effect changes that more closely approximate the physical appearance of the desired gender.

- **This document applies to eligible individuals who meet the clinical criteria and who have coverage under the scope and limitations of their benefit package. Services which are medically appropriate or indicated may not be approved for coverage based on exclusions and limitations of the benefit package.**

DEFINITIONS:

Gender dysphoria: An individuals' affective/cognitive discontent with the assigned gender or to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender and as a diagnostic category.

Transsexual: Individual who seeks, or has 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 genital surgery.

Transgender: A broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender.

PROCEDURE:

Requests for gender affirmation surgery are reviewed on a case-by-case basis.

I. Gender Affirming Surgical Procedures - Adults (> 18 years of Age)

Medically Necessary Gender Affirming Surgical Procedures

For medical necessity clinical coverage criteria using InterQual® criteria related to gendering affirming surgical procedures

Not Medically Necessary Gender Affirming Surgical Procedures

The following gender affirming surgical procedures may be considered not medically necessary when one or more of the medically necessary or reconstructive criteria requiring Prior Approval have not been met. Coverage is applicable to prior approval requirements and the applicable clinical coverage criteria using InterQual® criteria:

MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL

Page 2

- Bilateral Mastectomy
- Clitoroplasty
- Hysterectomy
- Labiaplasty
- Metoidioplasty
- Orchiectomy
- Ovariectomy
- Penectomy
- Phalloplasty
- Salpingo-Oophorectomy
- Scrotoplasty
- Urethroplasty
- Vaginectomy
- Vaginoplasty
- Trachea shave/reduction thyroid cartilage (chondroplasty)

**At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) or a master's level degree in a clinical behavioral science field (for example, M.S.W., L.C.S.W., Nurse Practitioner [N.P.], Advanced Practice Nurse [A.P.R.N.], Licensed Professional Counselor [L.P.C.], and Marriage and Family Therapist [M.F.T.]) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the specifications set forth above.

**The medical documentation should include the start date of living full time in the new gender. Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases.

II. Gender Affirming Surgical Procedures – Adolescents (< 18 years of Age)

Chest Surgery

Gender affirming chest surgery (top surgery) in individuals < 18 years of age (transgender men, trans men, or men of trans experience) [individuals who have gender identities as men and who were assigned female at birth]) may be considered medically necessary when **ALL** of the following criteria are met:

- The adolescent meets the diagnostic criteria of gender dysphoria; and
- The experience of gender diversity/incongruence is marked and sustained over time; and
- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; and
- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed: and

MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL

Page 3

- The adolescent has been informed of the reproductive effects, including the potential loss of infertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development; and
- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated; and
- The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures unless hormone therapy is either not desired or is medically contraindicated; and
- One letter of assessment signed from a member of the multidisciplinary team is required. This letter needs to reflect the assessment and opinion from the team that involves both qualified medical health care professional (HCPs) and qualified mental health professionals (MHPs); this letter must have been signed within 12 months of the request submission.

Note: It is recommended that the health care provider submitting a letter should have a master's level (e.g., M.S.W., L.C.S.W., Nurse Practitioner, Advanced Practice Nurse, Licensed Professional Counselor, Marriage and Family Therapist, general medical practitioner) degree at minimum or equivalent training in a relevant clinical field that is nationally accredited

Gender affirming chest surgery (top surgery) in individuals < 18 years of age (transgender men, trans men, or men of trans experience) [individuals who have gender identities as men and who were assigned female at birth]) not meeting the above criteria is considered **not medically necessary**.

Genital Surgery

- Requests for gender affirming genital surgery in an individual > 18 years of age will be reviewed on a case-by-case basis by a qualified Physician experienced in treating gender dysphoria.

Gender Affirming Surgeries Considered Cosmetic and Non-Covered Benefit

The following procedures when requested alone or in combination with other procedures are considered **cosmetic non-covered benefit**, when applicable reconstructive criteria have not been met (functional impairment cannot be identified), or when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender affirming surgery, including, but not limited to the following:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation (except when medical necessity criteria is met)
- Breast reduction
- Brow lift
- Calf implants
- Cheek augmentation or implants
- Chin augmentation (genioplasty, mentoplasty)

MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL

Page 4

- Face/Forehead lift/Forehead contouring or reshaping of any means such as frontal sinus setback, osteotomies, burring, augmentation, reduction, or fillers such as methylmethacrylate
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation (e.g., silicone implants, fat transfer, fat grafting)
- Hair removal (electrolysis or laser) (except when medical necessity criteria is met)
- Hairplasty (hair transplant), hair line lowering or raising or hairline advancements
- Injectable dermal fillers (e.g., Sculptra, Radiesse)
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement by any means
- Lipofilling/collagen injections
- Liposuction
- Mandibular advancement, reduction, reshaping, or contouring
- Mastopexy
- Medications for hair loss or growth hair
- Neck tightening or lifting (neck platysmaplasty)
- Nose implants
- Orbital rim osteotomies (reduction) or advancements
- Orthognathic procedures
- Otoplasty
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Rhytidectomy
- Tattooing
- Trachea shave/reduction thyroid cartilage (chondroplasty)
- Voice modification surgery such as vocal chondrolaryngoplasty

Surgical Revisions Following a Prior Approved Gender Affirmation Surgery

Reconstruction surgery following a prior approved gender affirmation surgery may be considered medically necessary when it is performed for ANY of the following reasons:

- Correct complications resulting from the initial surgery; or
- Correct a medical condition that resulted from the initial surgery that requires intervention; or
- Correct functional impairment resulting from the initial surgery.

Reconstruction surgery following a prior approved gender affirmation surgery not meeting the above criteria will be considered **not medically necessary**.

Surgery following gender affirmation surgery to reverse natural signs of aging or if the individual is not satisfied with the aesthetic result is considered **cosmetic and a noncovered benefit**.

Reversal of gender affirming surgery may be considered medically necessary if the individual meets the same criteria for gender dysphoria that was required for the original surgeries approved. For example, a transgender man (assigned female at birth) who wished to become a

**MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

Page 5

woman would need to meet **ALL** the criteria required for someone who was an assigned male at birth who wished to transition to transgender woman.

Reversal of gender affirming surgery will be considered **not medically necessary** when the above criteria is not met.

Medicare Coverage:

Per the National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9) and Article A53793, Billing and Coding: Gender Reassignment Services for Gender Dysphoria

References: Other Major Health Plan Guidelines
Medical Review Criteria – InterQual Guidelines

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