

GENDER REASSIGNMENT SURGERY

Effective Date: November 10, 2017

Review Dates: 8/15, 8/16, 11/16, 8/17

Date Of Origin: August 12, 2015

Status: Current

I. POLICY/CRITERIA

Gender reassignment surgery, including pre- and post-surgical hormone therapy, is considered medically necessary when **ALL** of the following criteria are met:

- 1) age 18 or older, **AND**
- 2) has confirmed gender dysphoria, **AND**
- 3) is an active participant in a recognized gender identity treatment program, **AND**
- 4) capacity to make a fully informed decision and to consent for treatment.

If medically necessary criteria for coverage for gender reassignment surgery are met, the following conditions of coverage apply.

- A. Breast surgery (i.e., initial mastectomy, breast reduction) is considered medically necessary for female to male patients when there is one letter of support from a qualified mental health professional.

Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

- B. Gonadectomy (Hysterectomy and salpingo-oophorectomy in female-to-male and orchiectomy in male-to-female patients) when **BOTH** of the following additional criteria are met:

1. Recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report). Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist, **AND**
2. Documentation of at least 12 months of continuous hormonal sex reassignment therapy.

- C. Genital Reconstructive surgery (i.e., including colpectomy vaginectomy, urethroplasty, metoidioplasty with initial phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male patients; including colovaginoplasty penectomy, vaginoplasty, labiaplasty, and clitoroplasty repair of introitus, construction of vagina with graft, coloproctostomy in male to female patients) when **ALL** of the following criteria are met:
1. Recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report). Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist, **AND**
 2. Documentation of at least 12 months of continuous hormonal sex reassignment therapy (May be simultaneous with real life experience.), **AND**
 3. The individual has lived within the desired gender role for at least 12 continuous months, which includes a wide range of life experiences and events (e.g., family events, holidays, vacations, season-specific work or school experiences), including notification to partners, family, friends, and community members (e.g., at school, work, other settings) of their identified gender.
- D. Procedures associated with gender reassignment surgery that are performed solely for the purpose of improving or altering appearance or self-esteem related to one's appearance, are considered cosmetic in nature and not medically necessary.

The following are considered cosmetic in nature and not medically necessary when performed as a component of a gender reassignment, even when there is a benefit for gender reassignment surgery (this list may not be all-inclusive):

- Blepharoplasty, brow reduction, brow lift
- Breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast
- Chin augmentation (reshaping or enhancing the size of the chin)
- Chin, nose, cheek implants
- Face lift, forehead lift
- Facial reconstruction for feminization or masculinization
- Forehead augmentation
- Gluteal and hip augmentation
- Hair reconstruction (removal or transplantation)

- Jaw/mandibular reduction or augmentation
- Liposuction, lipofilling
- Lip reduction or enhancement
- Mastopexy
- Nipple/areola reconstruction
- Pectoral implants
- Rhinoplasty
- Skin resurfacing (e.g. dermabrasion, chemical peel)
- Trachea shave (Adam’s apple shaving) or reduction thyroid chondroplasty
- Voice modification surgery

Note on gender specific services for the transgender community:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male trans-identified persons who have not undergone a mastectomy.
2. Prostate cancer screening may be medically necessary for male to female trans-identified persons who have retained their prostate.

II. MEDICAL NECESSITY REVIEW

Required Not Required Not Applicable

III. APPLICATION TO PRODUCTS

Gender reassignment surgery, including pre- and post-hormone therapy, is a covered service to the extent as required, limited, and/or enforceable by applicable state and/or federal law, and the above criteria are met, including being provided by a facility approved in advance by Priority Health. Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

Any procedure or treatment that is not medically/clinically necessary or is considered cosmetic, experimental or investigational, is not covered.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*

- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will not apply.*

IV. BACKGROUND

Gender reassignment therapy includes all medical procedures relating to gender reassignment of both transgender (i.e., internal gender identity is incongruent with genetic sex) and people with disorders of sexual development (DSD) (formerly known as “intersex”). The individual who is genetically male but whose gender identity is female, and who assumes a female gender presentation and role is known as a transwoman; and the individual who is genetically female but whose gender identity is male, and who assumes a male gender presentation and role is known as a transman.

The term "gender reassignment surgery," also known as sexual reassignment surgery, may be used to mean either the reconstruction of male or female genitals, specifically, or the reshaping, by any surgical procedure, of a male body into a body with female appearance, or vice versa. Gender reassignment surgery is part of a treatment plan for gender dysphoria. Gender dysphoria is defined as discomfort or distress that is caused by a discrepancy between a person’s gender identity and the person’s assigned sex at birth (World Professional Association for Transgender Health [WPATH], 2012), including the associated gender role and/or primary and secondary sex characteristics. Gender dysphoria can be alleviated through various treatments, some of which involve a change in gender expression or body modifications, such as hormones and/or surgery.

Mental health professionals play a strong role in working with individuals with gender dysphoria as they need to diagnose the gender disorder and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, and provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. Once the individual is evaluated, the mental health professional provides documentation and formal recommendations to medical and surgical specialists. Documentation recommending hormonal or surgical treatment should be comprehensive and include all of the following:

- individual’s general identifying characteristics

- the initial and evolving gender, sexual and psychiatric diagnoses
- details regarding the type and duration of psychotherapy or evaluation the individual received
- documentation of the extent to which eligibility criteria have been met
- the mental health professional's rationale for hormone therapy or surgery
- the degree to which the individual has followed the standards of care and likelihood of continued compliance
- whether or not the mental health professional is a part of a gender team

After diagnosis of gender dysphoria is made, the therapeutic approach is individualized but generally includes three elements: sex hormone therapy of the identified gender, real life experience in the desired role, and surgery to change the genitalia and other sex characteristics.

Hormone replacement therapy (HRT) plays an important role in the gender transition process whereby biological males are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Biological females are treated with testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes HRT may be effective in reducing the adverse psychologic impact of gender dysphoria. The individual identified with gender dysphoria also undergoes what is referred to as a "real life experience", prior to irreversible genital surgery, in which he/she adopts the new or evolving gender role and lives in that role as part of the transition pathway. This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During this time, a person would be expected to maintain their baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Gender reassignment surgery is intended to be a permanent change, establishing congruency between an individual's gender identity and physical appearance and is not easily reversible. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine and urological examination, and a clinical psychiatric/psychological examination. A patient's self-assessment and desire for sex reassignment cannot be viewed as reliable indicators of gender dysphoria.

V. CODING INFORMATION

ICD-10 Codes that must be reported on claims and preauthorization requests relative to gender reassignment procedures:

F64.0	Transsexualism
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/HCPCS Codes that may apply:

List should not be considered complete nor a guarantee of coverage:

55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
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
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
56625	Vulvectomy, simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
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
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)

- 58275 Vaginal hysterectomy, with total or partial vaginectomy
58552 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58571 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

VI. REFERENCES

World Professional Association for Transgender Health [WPATH], 2012

CMS, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N), August 30, 2016 @ <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282> (Retrieved September 19, 2016)

AMA CPT Copyright Statement:

All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.