Medical Policy

Gender Affirmation Surgeries

Policy Number: OCA 3.11
Version Number: 8
Version Effective Date: 01/01/20

Product Applicability

All Plan+ Products

Well Sense Health Plan
   Well Sense Health Plan

Boston Medical Center HealthNet Plan
   MassHealth ACO
   MassHealth MCO
   Qualified Health Plans/ConnectorCare/Employer Choice Direct
   Senior Care Options ◊

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at [www.SeniorsGetMore.org](http://www.SeniorsGetMore.org) to determine coverage guidelines for Senior Care Options.

Policy Summary

Gender affirmation surgeries (previously known as gender reassignment surgeries) are considered medically necessary as treatment options for a member seeking treatment for gender dysphoria when the Plan’s applicable medical criteria are met, as specified in this Plan policy. Gender affirmation surgeries may include one (1) or more surgical procedures and are part of a complex treatment plan involving medical, surgical, and behavioral health interventions to achieve the desired outcomes for the individual. When gender affirmation surgeries are requested for a Plan member, prior authorization is required and applicable Plan criteria must be met for each type of surgical procedure.

Gender Affirmation Surgeries

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It will be determined during the Plan’s prior authorization process if each requested procedure is considered medically necessary for the specified indication, with medical necessary defined in the Definitions section of this policy and included in the Plan’s Medically Necessary medical policy, policy number OCA 3.14. The Plan will review all requests for breast augmentation for male-to-female (MtF) members and mastectomy for female-to-male (FtM) members for gender affirmation using the medical criteria included in this Plan medical policy (rather than other Plan medical policies related to the requested breast procedures). Breast reconstruction for MtF members with persistent, well-documented gender dysphoria includes augmentation mammoplasty with implantation of breast prostheses and/or the medically necessary surgical removal of breast implants with replacement of breast implants after implant explantation. Review criteria in the Medical Policy Statement section of the Breast Reconstruction medical policy, policy number OCA 3.43, rather than the criteria included in this policy for Plan prior authorization guidelines for the surgical removal of breast implants and the replacement of breast implants after implant explantation when the breast implants were initially inserted for breast reconstruction as a component of gender affirmation surgeries.

The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member’s condition. See the member’s applicable benefit summary document (available at www.bmchp.org for BMC HealthNet Plan members, at www.SeniorsGetMore.org for Senior Care Options members, or at www.wellsense.org (Well Sense Health Plan members) for coverage of transgender services, including but not limited to office visits with behavioral, medical and/or surgical specialists, diagnostic services, hormone replacement therapy, and/or gender affirmation surgical procedures. Plan providers may review the Plan’s product-specific formulary, coverage guidelines for specific medications, and the list of drugs that require prior authorization for Plan members at https://www.bmchp.org/pharmacy/Providers for BMC HealthNet Plan members (including Senior Care Options members) and at https://www.wellsense.org/providers/pharmacy for Well Sense Health Plan members. Plan members may review the list of covered prescription medications and covered over-the-counter drugs online at https://www.bmchp.org/pharmacy/Members for BMC HealthNet Plan members, at www.SeniorsGetMore.org for Senior Care Options members, and at https://www.wellsense.org/members/pharmacy for Well Sense Health Plan members.

All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including the National Committee for Quality Assurance (NCQA). The Plan uses written medical criteria based on sound clinical evidence, and conducts all utilization review activities in accordance with applicable policies and procedures. Along with the appropriate Plan medical criteria, prior authorization staff considers the following factors for the member when applying the criteria to each request for individual consideration: age, co-morbidities, complications, progress of treatment, psychosocial circumstances, and environmental factors. Review the Plan’s Clinical Review Criteria administrative policy, policy number OCA 3.201.
Description of Item or Service

**Gender Affirmation Surgery:** One (1) or more surgical procedures used for the reconstruction of male or female genitals and/or the surgical reshaping of male or female body parts into the appearance of the preferred gender identity as a treatment for gender dysphoria. Gender affirmation surgery was previously known as gender reassignment surgery.

Medical Policy Statement

In addition to psychotherapy services, individuals diagnosed with gender dysphoria may need to access a variety of medical and/or surgical treatments based on their individual needs, including a range of procedures to change primary and/or secondary sex characteristics. The full range of medical and/or surgical treatment options available to individuals diagnosed with gender dysphoria may include, but are not limited to, those listed in professional medical publications such as Standards of Care, Version 7, World Professional Association for Transgender Health (WPATH), 2012.

External review will be available to the members enrolled in Qualified Health Plans, ConnectorCare, or Employer Choice Direct products when the Plan determines that coverage for treatment of gender dysphoria is NOT medically necessary or is experimental or investigational. Like external reviews for other types of medical services and treatments, the external review of services for Qualified Health Plans, ConnectorCare, or Employer Choice Direct members will be based upon the Massachusetts definition of medical necessity for the members enrolled in Qualified Health Plans, ConnectorCare, or Employer Choice Direct products. (Source: The Commonwealth of Massachusetts. Health Policy Commission. Memo: External Review for Denials of Coverage for Medical and/or Surgical Treatment of Gender Dysphoria. July 2, 2015.)

The Plan considers gender affirmation surgeries (previously known as gender reassignment surgeries) to be medically necessary for a member up to the specified coverage included in the member’s applicable benefit document (available at [www.bmchp.org](http://www.bmchp.org) for a BMC HealthNet Plan member, at [www.SeniorsGetMore.org](http://www.SeniorsGetMore.org) for a Senior Care Options member, or at [www.wellsense.org](http://www.wellsense.org) for a Well Sense Health Plan member) when medical record documentation supports that ALL applicable Plan criteria have been met, as specified below in items A through E:

### A. Referral/Initial Assessment by Qualified Licensed Mental Health Professional:

There is a referral/initial assessment from a qualified licensed mental health professional (as defined in the Definitions section of this Plan policy) that contains ALL of the following written documentation of the member’s condition, as specified below in items 1 through 3:

1. An assessment of the member’s gender identity and gender dysphoria resulting in a definitive diagnosis of persistent, well-documented gender dysphoria (meeting DSM 5 criteria, as specified in the Definitions section of this Plan policy and an ICD-10 diagnosis code included the
Applicable Coding section of this policy) by a clinician who has been treating the member and has confirmed the diagnosis of gender dysphoria; AND

2. The member’s availability of support from family, friends, and/or peers (such in-person or online contact with other transsexual, transgender, or gender non-conforming individuals or groups) as reported by the qualified licensed mental health professional treating the member; AND

3. The member’s psychological readiness for the requested procedure(s), including the member’s capacity to make a fully informed decision and has the capacity to consent for treatment(s), including parental or guardian consent (as applicable) if the member is younger than age 18 on the date of service unless the adolescent member is emancipated at the time the service is rendered; AND

B. Gender Role:

The member has been successfully living full time in the gender role that is congruent with the member’s gender identity for a minimum of 12 consecutive months as a real-life experience trial (with no returning to the member’s original gender); this includes members who identify as genders other than male or female; AND

□ Note: If a member is unable to successfully live full time in the member’s desired gender role for a minimum of 12 consecutive months, Plan Medical Director review and approval will be required for each requested gender affirmation surgical procedure. The treating provider must submit documentation indicating why it would be clinically inappropriate to require the member to meet this criterion and why this requirement should be waived.

C. Member Age:

The member is age 18* or older on the date of service; AND

* Note: Plan Medical Director review is required for any gender affirmation surgery for a member less than age 18 on the date of service. Requests for surgical treatment will be reviewed based on the Plan’s Medically Necessary medical policy, policy number OCA 3.14, and the current version of the WPATH Standards of Care for Health and Transsexual, Transgender, and Gender-Nonconforming People. In addition, the Plan Medical Director will review the member’s clinical situation, including but not limited to the amount of time the adolescent member has been living in the desired gender role, treatment timeframe with hormone therapy, age of the member, and the requested intervention. Adolescent members may be eligible for interventions when adolescents and their parents (or guardian) make informed decisions about treatment, and the service is a covered benefit for the Plan member. Informed consent by a parent or guardian for

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treatment of an adolescent member may not apply if the adolescent member is emancipated at the time the service is rendered (as determined by state requirements).

D. Procedure-Specific Criteria by Gender:

ALL of the following applicable criteria must be met for each of the requested gender affirmation surgical procedures and documented in the member’s medical record, as specified below in item 1, item 2, and item 3 (only for the requested surgical procedures):

1. The treating surgeon has obtained a written consent for the request surgical procedure(s) from the member (including parental or guardian consent, as applicable, if the member is younger than age 18 on the date of service unless the adolescent member is emancipated at the time the service is rendered); AND

2. ALL criteria specified above (in items A through C) must be met related to the referral/initial assessment, gender role, and member age; the procedure-specific criteria must be for each requested surgical procedure (listed below in item D3); and criteria for written clinical documentation from the treating surgeon must be met (outlined in item E below); AND

3. Only the procedure-specific criteria listed below related to the requested surgical procedure(s) would apply when determining medical necessity during the Plan’s prior authorization process. ALL of the procedure-specific criteria must be met for each of the requested procedures, as specified below in EITHER item a (male-to-female procedures) or item b (female-to-male procedures):

   a. Surgical Procedures for Male-to-Female (MtF) Members:

      (1) Breast Augmentation (Chest Reconstruction) for Male-to-Female (MtF) Members:

      This policy includes medical criteria for the initial breast augmentation procedure as a component of gender affirmation surgery. Breast reconstruction for MtF members with persistent, well-documented gender dysphoria includes augmentation mammoplasty with implantation of breast prostheses and/or the medically necessary surgical removal of breast implants with replacement of breast implants after implant explantation. Review criteria in the Medical Policy Statement section of the Breast Reconstruction medical policy, policy number OCA 3.43, rather than the criteria included in this policy for Plan prior authorization guidelines for the surgical removal of breast implants and the replacement of breast implants after implant explantation (when the breast implants were initially inserted for breast reconstruction as a component of gender affirmation surgery).

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Augmentation mammoplasty with implantation of breast prostheses (chest reconstruction) is considered medically necessary for male-to-female members with persistent, well-documented gender dysphoria when ALL of the following criteria are met for the initial breast augmentation for gender affirmation surgery, as specified below in items (a) through (d):

(a) The treating surgeon has reviewed the **written initial assessment by a qualified licensed mental health professional** (as defined in the Definitions section of this policy), and the treating surgeon has determined that the diagnosis of gender dysphoria is persistent, well-documented, and meets applicable DSM 5 criteria; AND

(b) The treating surgeon has determined that the member has the capacity to make a fully-informed decision and has the capacity to consent for treatment (including parental or guardian consent, as applicable, if the member is younger than age 18 on the date of service or informed consent is obtained from an emancipated minor according to state requirements); AND

(c) If significant medical and/or mental health concerns are present, the treating surgeon has determined that the conditions are being optimally managed and are reasonably well controlled; AND

(d) The member has had 24 continuous months of physician-supervised hormone therapy, but the treating provider has determined that the therapy has not resulted in sufficient breast development (unless hormone therapy is medically contraindicated for the member, and then this criterion is NOT applicable for the member).

(2) **Genital Surgery for Male-to-Female (MtF) Members:**

Genital surgical procedures are considered medically necessary for male-to-female members with persistent, well-documented gender dysphoria when ALL of the following criteria are met, as specified below in items (a) through (h):

(a) **ONE (1) or MORE** of the following procedures will be performed on a member with gender dysphoria, as specified below in items i through vi:

   i. Clitoroplasty/neoclitoroplasty; AND/OR

   ii. Labiaplasty/neolabiaplasty; AND/OR

   iii. Orchiectomy; AND/OR

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iv. Penectomy; AND/OR

v. Vaginoplasty/colovaginoplasty/neovaginoplasty; ∞ AND/OR

∞ Note: See the Limitations section for medically necessary guidelines for the removal of hair (using electrolysis and/or laser ablation treatments) on a skin graft when the skin graft will be used in a genital affirmation surgery (e.g., hair removal on skin graft donor site prior to its use for vaginoplasty/neovaginoplasty for MtF members).

vi. Vulvoplasty/neovulvoplasty; AND

(b) The treating surgeon is a board certified gynecologist, urologist, plastic surgeon, or general surgeon; AND

(c) The treating surgeon has reviewed the initial written assessment by a qualified licensed mental health professional (as defined in the Definitions section of this policy), and the treating surgeon has determined that the diagnosis of gender dysphoria is persistent, well-documented, and meets applicable DSM 5 criteria; AND

(d) The treating surgeon has determined that the member has the capacity to make a fully-informed decision and has the capacity to consent for treatment (including parental or guardian consent, as applicable, if the member is younger than age 18 on the date of service unless the adolescent member is emancipated at the time the service is rendered); AND

(e) If significant medical and/or mental health concerns are present, the treating surgeon has determined that the conditions are being optimally managed and are reasonably well controlled; AND

(f) The member has had 12 continuous months of full-time living in a gender role that is congruent with the member’s identity without returning to the original gender; AND

(g) The member has had 12 continuous months of physician-supervised hormone therapy appropriate to the member’s gender goals (unless hormone therapy is medically contraindicated for the member), and the timeframe for hormone therapy may be concurrent with living in gender role; AND
(h) The member has had a **written assessment completed by two (2) qualified licensed mental health professionals**+ (as defined in the Definitions section of this Plan policy) who have each independently assessed the member.

+ Note: One (1) of these two (2) written assessments may be from the qualified licensed mental health professional performing the initial assessment/referral referenced above in item A of this section (Referral/Initial Assessment criteria). When two (2) referrals/assessments are required and the first referral/assessment is from the member’s psychotherapist who has performed the initial assessment, the second referral may be an evaluative consultation and need not represent an ongoing therapeutic relationship.

b. **Surgical Procedures for Female- to-Male (FtM) Members:**

1. **Bilateral Mastectomy (Chest Reconstruction) for Female-to-Male (FtM) Members:**

   Hormone therapy is NOT a prerequisite for mastectomy with female-to-male members. Bilateral mastectomy (i.e., creation of a traditional, male-appearing chest) is considered medically necessary for a female-to-male member with persistent, well-documented gender dysphoria when ALL of the following criteria are met, as specified below in items (a) through (c):

   (a) The treating surgeon has reviewed the initial **written assessment by a qualified licensed mental health professional** (as defined in the Definitions section of this policy), and the treating surgeon has determined that the diagnosis of gender dysphoria is persistent, well-documented, and meets DSM 5 criteria; AND
   
   (b) The treating surgeon has determined that the member has the capacity to make a fully-informed decision and has the capacity to consent for treatment (including parental or guardian consent, as applicable, if the member is younger than age 18 on the date of service unless the adolescent member is emancipated at the time the service is rendered); AND
   
   (c) If significant medical and/or mental health concerns are present, the treating surgeon has determined that the conditions are being optimally managed and are reasonably well controlled.

2. **Genital Surgery for Female-to-Male (FtM) Members:**

   Genital surgery is considered medically necessary for a female-to-male member with persistent, well-documented gender dysphoria when ALL of the following criteria are met, as specified below in items (a) through (h):

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(a) ONE (1) or MORE of the following procedures will be performed, as specified below in items i through ix:

i. Hysterectomy; AND/OR

ii. Metoidioplasty; AND/OR

iii. Oophorectomy; AND/OR

iv. Phalloplasty with implantation of penile prosthesis; AND/OR

∞ Note: See the Limitations section for medically necessary guidelines for the removal of hair (using electrolysis and/or laser ablation treatments) on a skin graft when the skin graft will be used in a genital affirmation surgery (e.g., hair removal on skin graft donor site prior to its use for phalloplasty for FtM members).

v. Salpingectomy; AND/OR

vi. Scrotoplasty with insertion of testicular implants; AND/OR

vii. Urethroplasty; AND/OR

viii. Vaginectomy; AND/OR

ix. Vulvectomy; AND

(b) The treating surgeon is a board certified gynecologist, urologist, plastic surgeon, or general surgeon; AND

(c) The treating surgeon has reviewed the initial written assessment by a qualified licensed mental health professional (as defined in the Definitions section of this policy), and the treating surgeon has determined that the diagnosis of gender dysphoria is persistent, well-documented, and meets applicable DSM 5 criteria; AND

(d) The treating surgeon has determined that the member has the capacity to make a fully-informed decision and has the capacity to consent for treatment (including parental or guardian consent, as applicable, if the member is younger than age 18 on the date of service unless the adolescent member is emancipated at the time the service is rendered); AND

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(e) If significant medical and/or mental health concerns are present, the treating surgeon has determined that the conditions are being optimally managed and are reasonably well controlled; AND

(f) The member has had 12 continuous months of full-time living in a gender role that is congruent with the member’s identity without returning to the original gender; AND

(g) The member has had 12 continuous months of physician-supervised hormone therapy appropriate to the member’s gender goals (unless hormone therapy is medically contraindicated for the member), and timeframe for hormone therapy may be concurrent with living in gender role; AND

(h) The member has had a **written assessment completed by two (2) qualified licensed mental health professionals**+ (as defined in the Definitions section of this Plan policy), who have each independently assessed the member.

+ Note: One (1) of these two (2) written assessments may be from the qualified licensed mental health professional performing the initial assessment/referral referenced above in item A of this section (Referral/Initial Assessment criteria). When two (2) referrals/assessments are required and the first referral/assessment are from the member’s psychotherapist who has performed the initial assessment, the second referral may be an evaluative consultation and need not represent an ongoing therapeutic relationship.

E. **Required Written Clinical Documentation Submitted by the Treating Surgeon:**

Requests for prior authorization for a gender affirmation surgery must be submitted to the Plan by the surgeon (or the surgeon’s designee) performing the procedure and accompanied by written clinical documentation that supports the medical necessity for the procedure(s), as specified below in items 1 through 7:

1. A copy of the **initial assessment performed by a qualified licensed mental health professional** (as defined in the Definitions section of this Plan policy) resulting in a diagnosis of **gender dysphoria** that meets applicable DSM 5 criteria. At a minimum the assessment must include assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers; AND
2. If any significant coexisting mental health concerns are identified prior to a gender affirmation surgery, medical record documentation must show that they are being optimally managed and are reasonably well-controlled; AND

3. If any significant coexisting medical concerns are identified prior to a gender affirmation surgery, medical record documentation must show that they are being optimally managed and are reasonably well-controlled; AND

4. If living in an identity-congruent gender role is a required criterion for a gender affirmation surgery (as specified above in item D, Procedure-Specific Criteria), medical records must document the member’s experience in the gender role, including the start date of living full-time in the gender role. The Plan may request that the health care professional provide documentation of communications with individuals who have related to the member in an identity-congruent gender role; AND

5. If hormone therapy is a required criterion for a gender affirmation surgery, medical records must document member compliance with the prescribed regimen and clinical response over the course of hormone therapy; AND

6. A copy of the referral(s)/assessment(s) for the requested gender affirmation surgical procedure(s) from a qualified licensed mental health professional(s).

   One (1) referral/assessment from a qualified licensed mental health professional is required for mastectomy or augmentation mammoplasty.

   Two (2) referrals/assessments from qualified licensed mental health professionals who have independently assessed the member are required for genital surgery. When two (2) referrals/assessments are required and the first referral/assessment is from the member’s psychotherapist who has performed the initial assessment, the second referral/assessment may be an evaluative consultation and need not represent an ongoing therapeutic relationship.

   Each referral must be provided in the form of a letter and is required to address all of the topics outlined below, as specified in items a through e:

   a. The member’s general identifying characteristics (including date of birth); AND

   b. Results of the member’s psychosocial assessment, including any diagnoses; AND

   c. The duration of the mental health professional’s relationship with the member, including the type of evaluation and therapy or counseling to date; AND

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d. An explanation demonstrating that the criteria for surgery have been met (related to the referral/assessment from the qualified licensed mental health professional), and a brief description of the clinical rationale for supporting the member’s request for surgery; AND

e. A statement that the mental health professional is available for coordination of care and that a plan for coordination of care is in place; AND

7. A letter from the surgeon performing the gender affirmation surgical procedure(s) must confirm ALL of the following, as specified below in items a through f:

a. The member meets ALL the applicable medical criteria for coverage described in items A through D above; AND

b. The treating surgeon believes that it is likely that the procedure will alleviate or reduce the member’s gender dysphoria; AND

c. The treating surgeon has reviewed medical record documentation of the member’s past medical treatment for gender dysphoria (including feminizing/masculinizing hormone therapy, if applicable) and the member’s diagnosis of persistent and well-documented gender dysphoria; the treating surgeon will communicate with the qualified licensed mental health professional and any other health care professionals involved in the member’s care, if necessary; AND

d. The treating surgeon has personally communicated with the member and the member understands all of the different surgical techniques available and the advantages and disadvantages of each technique, the limitations of each technique to produce desired results, and the inherent risks and complications of the various techniques, including the surgeon’s own complication rate with respect to each technique; AND

e. If the surgery is likely to result in sterilization, at least ONE (1) of the following criteria is met, as specified below in item (1) or (2):

(1) The treating surgeon has discussed procedures for the preservation of fertility with the member prior to the surgery; AND/OR

(2) The member reports to the treating surgeon that procedures for the preservation of fertility have been previously reviewed to the member’s satisfaction with the treating independent licensed practitioner who initiated and provided the medical management of the member’s hormonal therapy; AND
f. The member’s treating surgeon, as well as the required qualified licensed health provider(s), have documented within six (6) months of the prior authorization request that there are no contraindications to the planned surgery and agree with the plan of care.

Limitations

1. The Plan does NOT consider gender affirmation surgeries (previously known as gender reassignment surgeries) to be medically necessary when applicable Plan criteria in the Medical Policy Statement section of this policy are NOT met.

2. If a member is unable to successfully live full time in the gender role that is congruent with the member’s gender identity for a minimum of 12 consecutive months as a real life experience (with no returning to the member’s original gender), Plan Medical Director review and approval will be required for each requested gender affirmation surgical procedure. This includes members who identify as genders other than male or female. The treating provider must submit documentation indicating why it would be clinically inappropriate to require the member to meet this criterion and why this requirement should be waived. All other applicable medical necessity criteria must be met for the requested gender affirmation surgery(ies), as specified in the Medical Policy Statement section.

3. External Review for Members Enrolled in the Qualified Health Plans, ConnectorCare, and/or Employer Choice Direct Products:

External review will be available to the members enrolled in Qualified Health Plans, ConnectorCare, or Employer Choice Direct products when the Plan determines that coverage for treatment of gender dysphoria is NOT medically necessary or the Plan considers the treatment experimental or investigational. Like external reviews for other types of medical services and treatments, the external review for Qualified Health Plans, ConnectorCare, or Employer Choice Direct products will be based upon the Massachusetts definition of medical necessity. (Source: The Commonwealth of Massachusetts, Health Policy Commission, Memo: External Review for Denials of Coverage for Medical and/or Surgical Treatment of Gender Dysphoria, July 2, 2015.)

4. Pediatric/Adolescent Members:

When a gender affirmation surgery is requested and is a covered benefit for a Plan member under the age of 18 on the date of service as specified in the member’s applicable benefit document (available at www.bmchp.org for a BMC HealthNet Plan member or at www.wellsense.org for a Well Sense Health Plan member), Plan Medical Director review is required. Requests for treatment will be reviewed individually by a Plan Medical Director based on the Plan’s Clinical Review Criteria policy, policy number OCA 3.201, and must meet ALL

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applicable Plan criteria for the requested procedure(s), as specified in the Medical Policy Statement section of this policy.

5. Breast Procedures:

Review the Medical Policy Statement section of this policy for Plan guidelines related to chest reconstructive procedures used to treat gender dysphoria. Plan Medical Director review is required for individual consideration when applicable criteria are NOT met for the requested surgical treatment or to determine the medical necessity of a chest reconstructive procedure NOT specified in the Medical Policy Statement and Applicable Coding sections of this policy when used as a treatment alternative for gender dysphoria (e.g., breast reconstruction with flaps, mastopexy, or breast reduction mammoplasty).

Breast reconstruction for MtF members with persistent, well-documented gender dysphoria may include the medically necessary surgical removal of breast implants and/or the replacement of breast implants after implant explantation (including when the implant was initially inserted as a component of a gender affirmation surgery); review the criteria in the Medical Policy Statement section of the Breast Reconstruction medical policy, policy number OCA 3.43, rather than the criteria included in this policy for Plan prior authorization guidelines for these surgical procedures.

6. Reversal of Gender Affirmation Surgery(ies):

When reversal of gender affirmation surgery(ies) is requested and is a covered benefit for a Plan member as specified in the member’s applicable benefit document (available at www.bmchp.org for a BMC HealthNet Plan member, at www.SeniorsGetMore.org for a Senior Care Options member, or at www.wellsense.org for a Well Sense Health Plan member), Plan Medical Director review is required. Requests for reversal of gender affirmation surgery(ies) will be reviewed individually by a Plan Medical Director based on the Plan’s Clinical Review Criteria administrative policy, policy number OCA 3.201.

7. Gender Incongruence:

The Plan considers gender affirmation surgery medically necessary for a definitive diagnosis of persistent, well-documented gender dysphoria when the Plan’s applicable medical necessity guidelines are met and according to the member’s benefit coverage. Plan Medical Director prior authorization review and approval will be required for individual consideration for gender incongruence according to the Plan’s Clinical Review Criteria administrative policy, policy number OCA 3.201, when the member’s diagnosis does NOT meet the definition of gender dysphoria (as specified in the Definitions section of this policy) and/or the member’s diagnosis is NOT consistent with a diagnosis code included in the Applicable Coding section of this policy. Medical record documentation must be submitted by the treating provider and should include

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all documentation related to the Plan’s applicable medical necessity criteria (as specified in the Medical Policy Statement section) related to the member’s gender incongruence, including but not limited to the following: description of member’s medical condition supporting the member’s plan of care, description of the member’s diagnosis of gender incongruence and why the member’s condition does NOT meet criteria for gender dysphoria (and/or an applicable diagnosis code included in the Applicable Coding section of this policy), and the member’s relevant comorbidities, behavioral health assessments, past medical/surgical history, prior treatments with clinical outcomes, and the gender affirmation surgical procedure(s) requested.

8. Hair Removal:

a. Cosmetic Hair Removal:

Hair removal, including laser epilation, intense pulsed light epilation, electrolysis, waxing, and/or any other method is considered cosmetic (and NOT medically necessary) when used to improve the gender-specific appearance of a member who has undergone or is planning to undergo a gender affirmation surgery.

b. Medically Necessary Hair Removal:

Electrolysis and/or laser ablation treatments for hair removal performed by a licensed and qualified treating provider may be considered medically necessary when it is part of the standard pre-operative preparation for genital affirming genital reconstruction/affirmation surgery(ies). Examples include perineal hair removal prior to vaginoplasty and the removal of hair on a skin graft for its use in gender affirming genital reconstruction surgery but must be approved by a Plan Medical Director (e.g., hair removal on skin graft donor site prior to its use for vaginoplasty with MtF members or hair removal on skin graft donor site prior to its use for phalloplasty for FtM members). Plan prior authorization is required to determine the medical necessity of hair removal (by verifying indication for hair removal) and to coordinate coverage for the member (since hair removal is generally considered cosmetic for other indications).

9. Cosmetic Procedures:

Cosmetic procedures related to the treatment of gender dysphoria are NOT considered medically necessary by the Plan. Procedures excluded from the Applicable Coding section of this Plan policy are NOT considered medically necessary; examples include but are not limited to ANY of the following, as specified below in items a through s:

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a. Blepharoplasty; OR

b. Body contouring procedures, including abdominoplasty, suction-assisted lipectomy, liposuction, and/or lipofilling; OR

c. Collagen injections; OR

d. Facial feminization surgery, facial bone reduction, or facial implants or injections; OR

e. Forehead augmentation; OR

f. Gluteal augmentation (implants and/or lipofilling); OR

g. Hair transplantation or hair reconstruction; OR

h. Laryngoplasty; OR

i. Lip reduction or lip enhancement; OR

j. Osteoplasty; OR

k. Otoplasty;

l. Pectoral implants; OR

m. Removal of redundant skin (UNLESS Plan medical necessity criteria are met, as specified in the Pan
ciculectomy and Related Redundant Skin Surgery medical policy, policy number OCA 3.722, available at www.bmchp.org for BMC HealthNet Plan members and Senior Care Options members or at www.wellsense.org for Well Sense Health Plan members); OR

n. Rhinoplasty; OR

o. Rhytidectomy; OR

p. Silicone injections of the breast; OR

q. Skin resurfacing; OR

r. Tattooing; OR

s. Voice modification/vocal cord surgery.
10. Laparoscopic prostatectomy as a component of gender affirmation surgical procedure(s) requires Plan Medical Director review.

11. Post-operative lodging is NOT routinely covered by the Plan; Plan Medical Director review is required for individual consideration.

12. Reimbursement for travel expenses is NOT covered by the Plan unless the Plan’s product-specific criteria are met, as specified in the Ambulance and Transportation Services medical policy, policy number OCA 3.191, available at www.bmchp.org for BMC HealthNet Plan members and Senior Care Options members or at www.wellsense.org for Well Sense Health Plan members.


14. Feminizing/masculinizing hormonal therapy and/or gender affirmation surgeries may limit the member’s fertility. Plan medical criteria for infertility services (covered for some Plan products) are listed in the Plan’s Infertility Services medical policy, policy number OCA 3.725; this medical policy and the member’s applicable benefit documents are available at www.bmchp.org for BMC HealthNet Plan members.

15. Plan Medical Director review is required for breast reconstruction when related to an adverse effect of a cosmetic breast procedure/treatment (e.g., the use of soft tissue fillers administered with injections of free silicone or other substances), the member has had NO diagnosis of breast cancer, and applicable criteria have NOT been met in the Medical Policy Statement of the Plan’s Breast Reconstruction medical policy, policy number OCA 3.43 rather than this Plan policy. To determine the medical necessity of breast reconstruction of the affected breast, the treating provider must provide the following medical record documentation: description of member’s medical condition supporting the member’s plan of care; applicable past medical/surgical history; prior treatments with clinical outcomes, complications, and adverse effects (including timeline of symptoms); diagnostic clinical findings; and the requested surgical procedure(s). When breast reconstruction is requested on the contralateral unaffected breast, medical record documentation must support the medical necessity of breast reconstruction for the contralateral breast in addition to the affected breast. All breast reconstruction requests must be evaluated using the Plan’s Breast Reconstruction medical policy, policy number OCA 3.43.

See the product-specific definitions of medical necessity in the Plan’s Medically Necessary medical policy, policy number OCA 3.14. For a Plan member enrolled in a Qualified Health Plans, ConnectorCare, or Employer Choice Direct product, review the Definitions section of this policy for the Gender Affirmation Surgeries

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definition of medical necessity or medically necessary for medical and/or surgical treatment of gender dysphoria for Plan members. Review the Plan’s Cosmetic, Reconstructive, and Restorative Services medical policy, policy number OCA 3.69, for the product-specific definitions of cosmetic services, cosmetic surgery, and/or reconstructive surgery and procedures.

Definitions

Allograft: The transplant of an organ or tissue from one individual to another individual of the same species.

Augmentation: The increasing, or growth, of something in number, amount, size, strength, or intensity, or the amount by which something is added to or grows.

Autograft: A tissue graft transferred from one part of an individual’s body to another part of the same individual’s body.

Blepharoplasty: Eyelid lift.

Breast Reconstruction: A series of surgical procedures performed to recreate a breast. Reconstructions are commonly done after one or both breasts are removed as a treatment for breast cancer or for other reasons, such as trauma or abnormalities that occur during breast development.

Clitoroplasty: Any plastic surgery procedure on the clitoris or surgical creation of a clitoris. In transsexual and transgender women, the procedure may be performed as part of sex affirmation surgery (neoclitoroplasty).

Colovaginoplasty: An operation where a vagina is created by cutting away a section of the sigmoid colon or ascending colon and using it to form a vaginal lining.

Colpectomy: (Also called a vaginectomy.) Plastic surgery of the vagina.

DSM 5 Criteria for Gender Dysphoria: The criteria for diagnosis of gender dysphoria in individuals, as adopted from the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5). The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least six (6) months’ duration, is manifested by at least TWO (2) of the following criteria, as specified below in items 1 through 6:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).

**Emancipation:** A legal process through which a minor child obtains a court order to end the rights and responsibilities that the child’s parent owe to the child such as financial support for the child and decision-making authority over the child. There can be either a partial or complete emancipation. In a partial emancipation, a child is free to make independent decisions but is still entitled to financial support from the child’s parents. In a complete emancipation a parent’s duty of child support is completely terminated. Complete emancipations are rare, and are usually found when there is a specific written agreement between the parent and minor child. Massachusetts and New Hampshire do not have formal laws or procedures for a minor to ask the court for an order of emancipation, and there are no formal guidelines for a court to follow. A child can ask the court in the Probate and Family Court of the county where the child lives to write an order for emancipation.

**Female-to-Male (FtM):** An individual born a phenotypical female (including an individual born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes) and later adopts the identity, appearance, and gender role of a male, especially after gender affirmation surgeries.

**Gender Dysphoria:** Discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex (physical gender) at birth. Only some gender nonconforming people will experience gender dysphoria in their lives. Criteria for the diagnosis of gender dysphoria can be found in the fifth edition of the American Psychiatric Association: Diagnosis and Statistical Manual of Mental Disorders (DSM 5). DSM-5 has replaced the diagnostic name “gender identity disorder (GID)” with “gender dysphoria” and specifies that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically **significant distress** associated with the condition. A diagnosis of gender incongruence does not include clinically significant distress associated with the condition and is NOT consistent with a diagnosis of gender dysphoria.
**Gender Identity:** An individual’s innermost concept of self (as male, female, a blend of male and female, or neither traditional male nor female) that can be either the same or different from their gender assigned at birth. For a Plan member enrolled in a Qualified Health Plans, ConnectorCare, or Employer Choice Direct product, Massachusetts law defines “gender identity” as “a person’s gender-related identity, appearance or behavior, whether or not that gender-related identity or behavior is different from that traditionally associated with the person’s physiology or assigned sex at birth. Chapter 199 of the Acts of 2011, The American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition defines gender dysphoria as the presence of “a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six (6) months. In children the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.” (Source: The Commonwealth of Massachusetts, Health Policy Commission, Memo: External Review for Denials of Coverage for Medical and/or Surgical Treatment of Gender Dysphoria, July 2, 2015.)

**Gender Nonconformity:** The extent to which a person’s gender identity, role, or expression differs from the cultural norms prescribed for people of a particular gender.

**Genioplasty:** An operation performed to reshape the chin.

**Hysterectomy:** The surgical removal of the uterus. It may also involve removal of the cervix, ovaries, fallopian tubes, and other surrounding structures.

**Introitus:** An entrance that goes into a canal or hollow organ. The vaginal orifice is an introitus.

**Labiaplasty:** Also known as labioplasty, labia minor reduction, and labial reduction, labiaplasty is a plastic surgery procedure for altering the labia minora (inner labia) and the labia majora (outer labia), the folds of skin surrounding the human vulva. In transsexual and transgender women, the procedure may be performed as part of sex affirming surgery (neolabiaplasty).

**Laparoscopy:** Also called minimally invasive surgery (MIS), bandaid surgery, or keyhole surgery, it is a modern surgical technique in which operations are performed far from their location through small incisions (usually 0.5–1.5 cm) elsewhere in the body.

**Male-to-Female (MtF):** An individual recorded male at birth but who has female gender identity. An individual born a phenotypical male (including an individual born with male reproductive organs and/or typical male karyotype with only one [1] X chromosome) and later adopts the identity, appearance, and gender role of a male, especially after gender affirming surgery(ies).

**Mammaplasty/Mammoplasty:** Surgery to alter the size or shape of the breast.
**Mastectomy:** Surgical removal of all or part of the breast and sometimes associated lymph nodes and muscles.

**Mastopexy:** A reconstructive surgical procedure used for therapeutic or cosmetic reformation of tissue to lift the breast (breast lift).

**Medical Necessity or Medically Necessary for Medical and/or Surgical Treatment of Gender Dysphoria (for a Plan Member Enrolled in a Qualified Health Plans, ConnectorCare, or Employer Choice Direct Product) When Applicable Service-Specific Medical Necessity Criteria are Met:** Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

1. Is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;

2. Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; OR

3. For services and interventions not in widespread use, is based on scientific evidence.

See G.L. c. 176O, § 1; 958 CMR 3.020; 211 CMR 52.03. (Source: The Commonwealth of Massachusetts, Health Policy Commission, Memo: External Review for Denials of Coverage for Medical and/or Surgical Treatment of Gender Dysphoria, July 2, 2015.) Review the product-specific definitions of medically necessary in the Plan’s *Medically Necessary* medical policy, policy number OCA 3.14.

**Medical Necessity or Medically Necessary for Medical and/or Surgical Treatment of Gender Dysphoria for a Plan Member Enrolled in a Senior Care Options Product When Applicable Service-Specific Medical Necessity Criteria are Met:** See the product-specific definitions of medically necessary in the Plan’s *Medically Necessary* medical policy, policy number OCA 3.14.

**Medical Necessity or Medically Necessary for Medical and/or Surgical Treatment of Gender Dysphoria for a Plan Member Enrolled in a Well Sense Health Plan Product When Applicable Service-Specific Medical Necessity Criteria are Met:** See the product-specific definitions of medically necessary in the Plan’s *Medically Necessary* medical policy, policy number OCA 3.14.

**Metoidioplasty:** A surgical procedure generally performed after a period of testosterone therapy, which enlarges the clitoris and its extended erectile tissue. The clitoris is then freed from its normal position and moved forward to approximate the location of a penis, and the urethra is extended. It is an alternative to phalloplasty for transgender men.
**Oophorectomy:** The surgical removal of one or both ovaries. It is also called ovariectomy or ovarian ablation.

**Orchiectomy:** Surgical excision of one or both testes; castration.

**Osteoplasty:** Plastic surgery on bone.

**Osteotomy:** Taking out all or part of a bone, or cutting into or through a bone for repositioning (e.g., orthognathic surgery for mandibular angle reshaping, chin reduction, forehead recontouring, brow lift and scalp advancement).

**Penectomy:** Surgical removal of part or the entire penis.

**Penile Prosthesis:** Either semi rigid (non-inflatable) or inflatable cylinders that replace the spongy tissue (corpora cavernosum) inside the penis that fills with blood during an erection.

**Perineoplasty:** Plastic surgery procedures used to correct clinical conditions which have caused damage, defect, or deformity of the vagina and the anus.

**Phalloplasty:** A surgical procedure used to create a surrogate penis (including individuals born with male reproductive organs and/or typical male karyotype with only one [1] X chromosome) who either have congenital defects or have lost part or the entire penis in a traumatic incident, or who are transgender men.

**Physical Interventions for Adolescents:** (Source: WPATH Version 7 Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People.) Physical interventions for adolescents fall into three (3) categories or stages (Hembree et al., 2009), as specified below in items 1 through 3:

1. **Fully-Reversible Interventions:** These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. **Partially-Reversible Interventions:** These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. **Irreversible Interventions:** Surgical procedures.

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Gender Affirmation Surgeries

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Prostatectomy: Removal of prostate.

Qualified Licensed Mental Health Professional: A mental health professional who diagnoses and treats individuals presenting for care regarding their gender identity or gender dysphoria and who possess ALL of the following minimum credentials, as specified below in items 1 through 7:

1. A minimum of a master’s degree or equivalent in a clinical behavioral science field from an institution accredited by the appropriate national accrediting board and is independently licensed by the relevant licensing board to practice in the state in which the practitioner practices (i.e., Massachusetts or New Hampshire); AND

2. Competence in using the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders for diagnostic purposes; AND

3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria; AND

4. Documented supervised training and competence in psychotherapy or counseling; AND

5. Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; AND

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; and/or participating in research related to gender nonconformity and gender dysphoria; AND

7. Develops and maintains cultural competence to facilitate the provider’s work with transsexual, transgender, and gender-nonconforming clients, which may include being knowledgeable about relevant community, advocacy, and public policy issues and can assess and treat sexual health concerns and disorders.

Revision of Reconstructed Breast: Revisions may be needed to improve the appearance of the breast, reduce the breast size, improve breast projection or shape, reduce excess tissue, or revise mastectomy/lumpectomy/IV port scars.

Rhinoplasty: Plastic surgery in which the structure of the nose is changed. The change can be made by adding or removing bone or cartilage, grafting tissue from another part of the body, or implanting synthetic material to alter the shape of the nose (i.e. “nose job”).

Rhytidectomy: Plastic surgery to eliminate wrinkles from the skin by excising loose or redundant tissue.
**Salpingo-oophorectomy:** The surgical removal of a fallopian tube and an ovary.

**Scrotoplasty:** Plastic surgery to repair or refashion the scrotum.

**Tattooing:** A permanent picture, design, or other marking made on the skin by pricking it and staining it with an indelible dye.

**Tissue Expander or Expansion:** A fillable tube or device used by plastic and restorative surgeons to cause the body to grow additional skin, bone, or other tissues. Inflatable reservoirs, usually made of silicone, which are implanted subcutaneously in order to generate tissue needed for surgical reconstruction. After implantation, the reservoir is inflated over several weeks by percutaneous injection of fluid. Once the tissue has grown, the expander is surgically removed and the expanded skin is used to cover the area being reconstructed.

**Tissue Transfer or Rearrangement:** Transfer or transplantation of healthy, flat sections of skin or other tissue adjacent to a wound, scar, or other lesion. The flaps of skin remain connected at one or more of their borders and are moved to an adjacent or nearby defect and attached in their entirety to their new location. These are commonly referred to as "local flaps" since tissue near or local to the defect is moved on to it.

**Transgender:** Diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from their sex recorded at birth.

**Urethra:** The tube that leads from the bladder and transports and discharges urine outside the body. In phenotypical males (including individuals born with male reproductive organs and/or typical male karyotype with only one [1] X chromosome), the urethra travels through the penis and carries semen as well as urine. In phenotypical females (including individuals born with female reproductive organs and/or typical female karyotype with two [2] X chromosomes), the urethra is shorter than in the phenotypical male (including individuals born with male reproductive organs and/or typical male karyotype with only one [1] X chromosome), and it emerges above the vaginal opening.

**Urethroplasty:** Repair of an injury or defect within the walls of the urethra. Urethroplasty may also be performed as a component of genital surgery for gender affirmation for a female-to-male individual.

**Vaginectomy:** Surgical removal of all or part of the vagina. Vaginectomy is also used as part of some types of female-to-male sex affirmation surgeries with the removal of testis membrane and surgical removal of all or part of the smooth moist membrane that encloses the testis and epididymis.

**Vaginoplasty:** Plastic surgery of the vagina; also known as colpoplasty. In transsexual and transgender women, the procedure may be performed as part of sex affirmation surgeries (neovaginoplasty).
**Vulvectomy:** Gynecological procedure in which the vulva is partly or completely removed (which may include the labia, clitoris, and entrance to the vagina).

**Vulvoplasty:** Surgical correction of the vulva in phenotypical females (including individuals born with female reproductive organs and/or typical female karyotype with two \([2] \) X chromosomes). The two \((2)\) most popular types of vulvoplasty are labial reduction for correcting enlarged labia minora or misshaped labia minora, and vaginal tightening surgery or vaginoplasty, for correcting vaginal relaxation or a loose vagina. In transsexual and transgender women, the procedure may be performed as part of sex affirmation surgeries (neovulvoplasty). For genital sex affirmation in male-to-female transsexuals, surgical procedures may include vaginoplasty, preferably by inversion of penoscrotal skin flaps, clitoroplasty, and vulvoplasty.

**World Professional Association of Transgender Health (WPATH):** Organization founded in 1979 that has developed internationally accepted standards of care for the treatment of gender dysphoria/gender incongruence.

### Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See the applicable Plan reimbursement policies for Plan billing guidelines.

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**ICD-10 Codes**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description: The following primary diagnosis codes apply to gender dysphoria and require prior authorization when billed with a medically necessary procedure code covered by the Plan, as specified below.</th>
</tr>
</thead>
<tbody>
<tr>
<td>F64.0-F64.9</td>
<td>Gender identity disorders</td>
</tr>
<tr>
<td>Z87.890</td>
<td>History of sex reassignment surgery</td>
</tr>
</tbody>
</table>

**Plan note:** Each gender affirmation surgery requires Plan prior authorization for ALL diagnosis codes, even if not included in this Applicable Coding section. See the member’s applicable benefit document to determine coverage of services. Plan Medical Director review and approval will be required for each gender affirmation surgery when the member has a diagnosis of gender incongruency (without a diagnosis of gender dysphoria).

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description: Codes covered when medically necessary for the treatment of gender dysphoria if applicable Plan criteria are met (for ALL submitted/billed primary diagnosis codes related to gender dysphoria).</th>
</tr>
</thead>
<tbody>
<tr>
<td>19301</td>
<td>Mastectomy partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)</td>
</tr>
<tr>
<td>19303</td>
<td>Mastectomy, simple, complete</td>
</tr>
<tr>
<td>19324</td>
<td>Mammaplasty, augmentation; without prosthetic implant</td>
</tr>
<tr>
<td>19325</td>
<td>Mammaplasty, augmentation; with prosthetic implant</td>
</tr>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
</tr>
<tr>
<td>53430</td>
<td>Urethroplasty, reconstruction of female urethra</td>
</tr>
</tbody>
</table>

**Plan note:** Procedure may be performed as a component of gender affirmation surgeries for a phenotypical female, including an individual born with female reproductive organs and/or with typical female karyotype with two (2) X chromosomes, when applicable Plan medical criteria are met.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description: Codes covered when medically necessary for the treatment of gender dysphoria if applicable Plan criteria are met (for ALL submitted/billed primary diagnosis codes related to gender dysphoria).</th>
</tr>
</thead>
<tbody>
<tr>
<td>54120</td>
<td>Amputation of penis; partial</td>
</tr>
<tr>
<td>54125</td>
<td>Amputation of penis; complete</td>
</tr>
<tr>
<td>54400</td>
<td>Insertion of penile prosthesis; non-inflatable (semi-rigid)</td>
</tr>
<tr>
<td>54401</td>
<td>Insertion of penile prosthesis; inflatable (self-contained)</td>
</tr>
<tr>
<td>54405</td>
<td>Insertion of multi-component inflatable penile prosthesis, including placement of pump, cylinders, and reservoir</td>
</tr>
<tr>
<td>54520</td>
<td>Orchietectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach</td>
</tr>
<tr>
<td>54660</td>
<td>Insertion of testicular prosthesis (separate procedure)</td>
</tr>
<tr>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy</td>
</tr>
<tr>
<td>55175</td>
<td>Scrotoplasty; simple</td>
</tr>
<tr>
<td>55180</td>
<td>Scrotoplasty; complicated</td>
</tr>
</tbody>
</table>
**Gender Affirmation Surgeries**

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Plan Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>55970</td>
<td>Intersex surgery; male to female</td>
<td>Series of staged procedures to remove penis and create vagina.</td>
</tr>
<tr>
<td>55980</td>
<td>Intersex surgery; female to male</td>
<td>Series of staged procedures to remove or close vagina and for penis and testes.</td>
</tr>
<tr>
<td>56620</td>
<td>Vulvectomy simple; partial</td>
<td></td>
</tr>
<tr>
<td>56625</td>
<td>Vulvectomy simple; complete</td>
<td></td>
</tr>
<tr>
<td>56800</td>
<td>Plastic repair of introitus</td>
<td></td>
</tr>
<tr>
<td>56805</td>
<td>Clitoroplasty for intersex state</td>
<td></td>
</tr>
<tr>
<td>56810</td>
<td>Perineoplasty, repair of perineum, nonobstetrical (separate procedure)</td>
<td></td>
</tr>
<tr>
<td>57106</td>
<td>Vaginectomy, partial removal of vaginal wall</td>
<td></td>
</tr>
<tr>
<td>57107</td>
<td>Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)</td>
<td></td>
</tr>
<tr>
<td>57110</td>
<td>Vaginectomy, complete removal of vaginal wall</td>
<td></td>
</tr>
<tr>
<td>57111</td>
<td>Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)</td>
<td></td>
</tr>
<tr>
<td>57291</td>
<td>Construction of artificial vagina; without graft</td>
<td></td>
</tr>
<tr>
<td>57292</td>
<td>Construction of artificial vagina; with graft</td>
<td></td>
</tr>
<tr>
<td>57335</td>
<td>Vaginoplasty for intersex state</td>
<td></td>
</tr>
<tr>
<td>58150</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)</td>
<td></td>
</tr>
<tr>
<td>58180</td>
<td>Supracervical abdominal hysterectomy (subtotal hysterectomy) with or without removal of tube(s), with or without removal of ovary(s)</td>
<td></td>
</tr>
<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250g or less</td>
<td></td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy, for uterus 250g or less; with removal of tube(s), and/or ovary(s)</td>
<td></td>
</tr>
<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy</td>
<td></td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250g</td>
<td></td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)</td>
<td></td>
</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less</td>
<td></td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)</td>
<td></td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g</td>
<td></td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)</td>
<td></td>
</tr>
<tr>
<td>58550</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less</td>
<td></td>
</tr>
<tr>
<td>58552</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)</td>
<td></td>
</tr>
</tbody>
</table>
Gender Affirmation Surgeries

Plan note: Electrolysis is considered cosmetic when used to improve the gender-specific appearance of a member who has undergone or is planning to undergo a gender affirmation surgery. Electrolysis treatments performed by a licensed dermatologist or treating provider may be considered medically necessary for the removal of hair on a skin graft donor site when the skin graft will be used for a genital gender affirmation surgery but must be approved by a Plan Medical Director (e.g., hair removal on skin graft donor site prior to its use for vaginoplasty with MtF members or hair removal on skin graft donor site prior to its use for phalloplasty for FtM members).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description: Codes may be considered cosmetic or medically necessary based on indication for treatment and type of service provided for gender dysphoria (for billed primary ICD-10 diagnosis codes listed above).</th>
</tr>
</thead>
<tbody>
<tr>
<td>17380</td>
<td>Electrolysis epilation, each 30 minutes</td>
</tr>
<tr>
<td></td>
<td>Plan note: Electrolysis is considered cosmetic when used to improve the gender-specific appearance of a member who has undergone or is planning to undergo a gender affirmation surgery. Electrolysis treatments performed by a licensed dermatologist or treating provider may be considered medically necessary for the removal of hair on a skin graft donor site when the skin graft will be used for a genital gender affirmation surgery but must be approved by a Plan Medical Director (e.g., hair removal on skin graft donor site prior to its use for vaginoplasty with MtF members or hair removal on skin graft donor site prior to its use for phalloplasty for FtM members).</td>
</tr>
<tr>
<td>17999</td>
<td>Unlisted procedure, skin, mucous membrane and subcutaneous tissue</td>
</tr>
<tr>
<td></td>
<td>Plan notes:</td>
</tr>
<tr>
<td></td>
<td>1. Code used when billing for laser ablation for hair removal on a skin graft donor site for a genital gender affirmation surgery.</td>
</tr>
<tr>
<td></td>
<td>2. Laser ablation/laser hair removal treatments are considered cosmetic when used to improve the gender-specific appearance of a member who has undergone or is planning to undergo a gender affirmation surgery. Laser ablation treatments performed by a licensed dermatologist or treating provider may be considered medically necessary for the removal of hair on a skin graft donor site when the skin graft will be used for a genital gender affirmation surgery.</td>
</tr>
</tbody>
</table>
Gender affirmation surgeries but must be approved by a Plan Medical Director (e.g., hair removal on skin graft donor site prior to its use for vaginoplasty with MtF members or hair removal on skin graft donor site prior to its use for phalloplasty for FtM members).

Clinical Background Information

The Plan utilizes standards of care (SOC) developed by the World Professional Association for Transgender Health (WPATH) to establish Plan medical criteria for gender affirmation surgeries (previously known as gender reassignment surgeries). WPATH is an international and multidisciplinary, professional organization dedicated to transsexual and transgender health. According to WPATH, the goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender non-conforming people with individualized healthcare needs. WPATH acknowledges the need for individuals to make informed choices and validates various expressions of gender which may or may not necessitate psychological, hormonal, and/or surgical treatments.

Individuals with gender dysphoria may experience a level of distress that meets criteria for a formal diagnosis of a mental disorder based on the standard classification of mental disorders in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). A mental disorder is a description of a medical condition and does not define a person’s identity as a transsexual, transgender, and/or gender non-conforming individual. For individuals seeking treatment for gender dysphoria, a variety of therapeutic options can be considered, including psychotherapy, change in gender role, hormone therapy, and gender affirmation surgeries.

Many people with gender dysphoria will undergo hormonal treatments for varying periods of time to feminize or masculinize the body, to suppress natal sex characteristics, and/or express desired sex characteristics. Informed consent is essential before hormone therapy is initiated, since feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Providers must document in the member’s medical record that comprehensive information was provided to the member and the member understood all aspects of treatment before the therapy was initiated, including the benefits and risks of hormone therapy. Health care professionals must discuss reproductive options with patients prior to initiation of medical treatments that will limit infertility, including hormone therapy and/or gender affirmation surgeries.

Gender affirmation surgeries are a series of surgical procedures performed to change a person’s primary and/or secondary sex characteristics to conform to those of another gender. The number and sequence of these procedures varies from person to person, according to their individual needs and established clinical guidelines. Natal males who are transitioning to female are referred to as male-to-female (MtF), and natal females who are transitioning to male are referred to as female-to-male (FtM).

Psychological and educational counseling with professionals experienced in the treatment of gender nonconformity is desirable for members with gender dysphoria. Psychotherapy allows individuals to
explore gender identity, role, and expression, as well as addressing the negative impact of gender dysphoria and methods to improve body image. Mental health professionals may provide psychological support to individuals by assessing, diagnosing, and discussing treatment options for individuals with gender dysphoria and/or other mental health concerns. It is important that the mental health professional(s) work collaboratively with other treating practitioners in the coordination of the member’s care. It is recommended that patients engage in at least 12 continuous months of living in a gender role that is congruent with their identity before undergoing gender affirmation surgeries; this allows the individual to experience and socially adjust to the desired gender role before the surgical procedure.

There are a number of differences in the development and treatment of gender dysphoria in children, adolescents, and adults. Gender dysphoria during childhood does not inevitably continue into adulthood, often disappearing by early puberty. However, gender dysphoria in children that intensifies with the onset of puberty rarely subsides.

There may be risks associated with withholding medical treatment for adolescents with gender dysphoria. According to WPATH SOC Version 7, “Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescents (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.” WPATH SOC recommend individual consideration for partially-reversible and irreversible physical interventions for adolescents. Early evaluation of children with gender identity disorder (GID) by experienced professionals is recommended to prevent self-injurious behavior or other psychiatric difficulties.

For situations in which deferral of gender-affirmation decisions until adulthood is not clinically feasible, one treatment approach (under the care of a pediatric endocrinologist with consultation from a qualified licensed mental health professional) is the use of sex hormone suppression that reversibly delays the development of secondary sexual characteristics. The goals of such treatment are to avoid distress caused by unwanted secondary sexual characteristics, to minimize the later need for surgery to reverse them, and to delay the need for treatment decisions until maturity allows the adolescent to participate in providing informed consent regarding transition to living as the other sex.

According to Centers for Medicare & Medicaid Services (CMS) Pub 100-02 Medicare Benefit Policy Transmittal 189 dated June 27, 2014 and CMS Pub 100-03 Medicare National Coverage Determinations (NCD) Transmittal 169 dated June 27, 2014, Medicare coverage for transsexual surgery will be determined by the local Medicare Administrative Contractors (MAC). The Department of Health and Human Services (DHHS) Departmental Appeals Board (Appellate Division) decision number 2576 dated May 30, 2014 determined that the NCD 140.3 denying Medicare coverage of all transsexual surgery as a treatment for transsexualism is NOT valid and local coverage determinations (LCDs) used to adjudicate such claims may NOT rely on the provisions of the NCD 140.3; this DHHS decision does not apply.
bar CMS or its contractors from denying individual claims for payment for transsexual surgery for other reasons permitted by law. (The invalidation of NCD 140.3 - Transsexual Surgery was effective for claims with dates of service on and after May 30, 2014.)

As of August 30, 2016, the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) states that local Medicare Administrative Contractors (MACs) will continue to determine coverage of gender affirmation surgeries for gender dysphoria on a case-by-case basis for Medicare beneficiaries; CMS has not issued an NCD at this time because the clinical evidence for this service is inconclusive for the Medicare population. In the absence of a national policy, MACs will make the determination of whether or not to cover gender affirmation surgeries based on whether each gender affirmation surgery is reasonable and necessary for the individual beneficiary after considering the individual’s specific circumstances. Verify if applicable CMS criteria are in effect for gender affirmation surgeries in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member.

References


Gender Affirmation Surgeries

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**Policy History**

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Original Policy Approved by</th>
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</thead>
<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>07/01/15 Version 1</td>
<td>Medical Policy Manager as Chair of MPCTAC</td>
<td>MPCTAC and QIC</td>
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<tr>
<td>Internal Approval: 03/18/15: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 04/08/15: Quality Improvement Committee (QIC)</td>
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*Effective Date for the Senior Care Options Product(s): 01/01/16  
*Effective Date for the Well Sense Health Plan Product(s): 07/01/17

Policy title *Gender Reassignment Surgery* from 01/01/16 to 05/31/18. Policy title changed to *Gender Affirmation Surgeries* as of 06/01/18.

**Policy Revisions History**

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
</tr>
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<tbody>
<tr>
<td>09/01/15</td>
<td>Review for effective date 01/01/16. Updated criteria in the Medical Policy Statement and Limitations sections. Removed requirement for 18 months of treatment for gender dysphoria. Added guidelines on external review for services denied by the Plan when members are enrolled in Qualified Health Plans, ConnectorCare, and/or Employer Choice Direct products. Update the Summary, Clinical Background Information, Definitions, and References sections and the list of applicable products.</td>
<td>01/01/16 Version 2</td>
<td>09/16/15: MPCTAC 10/14/15: QIC</td>
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<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated language in the Applicable Coding section.</td>
<td>01/01/16 Version 3</td>
<td>11/25/15: MPCTAC (electronic vote) 12/09/15: QIC</td>
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<tr>
<td>04/01/16</td>
<td>Review for effective date 08/01/16. Revised the Definitions, Clinical Background Information, References, and Reference to Applicable Laws and</td>
<td>08/01/16 Version 4</td>
<td>04/20/16: MPCTAC 05/23/16: QIC</td>
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</tbody>
</table>

Gender Affirmation Surgeries

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<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Effective Date</th>
<th>Version</th>
<th>Notes</th>
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<tbody>
<tr>
<td>07/05/16</td>
<td>Review for effective date 10/01/16. Revised criteria in the Medical Policy Statement and Limitations section. Revised the applicable code list and added Plan notes to codes. Updated Summary and References sections.</td>
<td>10/01/16</td>
<td>Version 5</td>
<td>07/05/16: MPCTAC (electronic vote) 07/13/16: QIC</td>
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<tr>
<td>09/01/16</td>
<td>Review for effective date 10/01/16. Added reference to the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) effective 08/30/16 in the Clinical Background Information and References sections. CMS industry-wide update with no change to criteria and/or the applicable code list for Plan members (including members enrolled in a SCO product).</td>
<td>10/01/16</td>
<td>Version 6</td>
<td>Not applicable because industry-wide update of CMS guidelines with no change to criteria and/or the applicable code list</td>
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<td>09/28/16</td>
<td>Review for effective date 11/01/16. Administrative changes made to clarify language related to gender. Revised Definitions section.</td>
<td>11/01/16</td>
<td>Version 7</td>
<td>09/30/16: MPCTAC (electronic vote) 10/12/16: QIC</td>
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<td>06/01/17</td>
<td>Review for effective date 07/01/17. Added the Well Sense Health Plan products as applicable new products for this policy as of 07/01/17 with the necessary administrative changes made to the Medical Policy Statement, Summary, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Well Sense Health Plan criteria added in product-specific Medical Policy Statement section and product-specific Limitations section.</td>
<td>07/01/17</td>
<td>Version 8</td>
<td>06/21/17: MPCTAC</td>
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<tr>
<td>05/01/17</td>
<td>Review for effective date 08/01/17. Criteria for BMC HealthNet Plan products were revised in the Medical Policy Statement section in 05/17 (with adequate provider notification); new criteria are effective 08/01/17 for BMC HealthNet Plan products. Administrative changes made to the Summary, Definitions, and References sections.</td>
<td>08/01/17</td>
<td>Version 9</td>
<td>05/17/17: MPCTAC</td>
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<tr>
<td>06/01/17</td>
<td>Review for effective date 08/01/17. Administrative change made to combine criteria in the Medical Policy Statement sections and in the Limitations sections for all BMC HealthNet Plan products and Well Sense Health Plan products (since all criteria</td>
<td>08/01/17</td>
<td>Version 10</td>
<td>06/21/17: MPCTAC</td>
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Policy Revisions History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision Details</th>
<th>Version</th>
<th>Effective Date</th>
<th>Authorizing Entity</th>
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<tbody>
<tr>
<td>03/01/18</td>
<td>Review for effective date 06/01/18. Revised policy title. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections. Coding updated and Plan notes revised in the Applicable Coding section.</td>
<td>06/01/18 Version 11</td>
<td>03/21/18: MPCTAC</td>
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</tr>
<tr>
<td>05/01/19</td>
<td>Review for effective date 08/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Criteria updated in the Medical Policy Statement and Limitations sections. Coding updated in the Applicable Coding section.</td>
<td>08/01/19 Version 12</td>
<td>05/15/19: MPCTAC</td>
<td></td>
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<tr>
<td>12/01/19</td>
<td>Review for effective date 01/01/20. Industry-wide update to coding (as a code deletion) included in the Applicable Coding section.</td>
<td>01/01/20 Version 13</td>
<td>Not applicable because industry-wide code changes</td>
<td></td>
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</table>

Last Review Date
12/01/19

Next Review Date
04/01/20

Authorizing Entity
MPCTAC

Other Applicable Policies

Administrative Policy - Clinical Review Criteria, policy number OCA 3.201
Medical Policy - Ambulance and Transportation Services, policy number OCA 3.191
Medical Policy - Breast Reconstruction, policy number OCA 3.43
Medical Policy - Breast Reduction Mammoplasty, policy number OCA 3.44
Medical Policy - Cosmetic, Reconstructive, and Restorative Services, policy number OCA 3.69

Gender Affirmation Surgeries

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Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
Medical Policy - *Gynecomastia Surgery*, policy number OCA 3.48
Medical Policy - *Infertility Services*, policy number OCA 3.725
Medical Policy - *Mastopexy*, policy number OCA 3.717
Medical Policy - *Medically Necessary*, policy number OCA 3.14
Medical Policy - *Panniculectomy and Related Redundant Skin Surgery*, policy number OCA 3.722
Medical Policy - *Skin Substitutes in the Outpatient Setting*, policy number OCA 3.710
Reimbursement Policy - *Ambulatory Surgical Center - Facility*, policy number SCO 4.114
Reimbursement Policy - *Ambulatory Surgery Center*, policy number WS 4.31
Reimbursement Policy - *Anesthesia*, policy number 4.103
Reimbursement Policy - *Anesthesia*, policy number SCO 4.103
Reimbursement Policy - *Anesthesia*, policy number WS 4.11
Reimbursement Policy - *Bilateral and Multiple Procedure Reductions*, policy number 4.607
Reimbursement Policy - *Bilateral and Multiple Procedure Reductions*, policy number SCO 4.607
Reimbursement Policy - *Free Standing Surgical Facility Services*, policy number 4.114
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number WS 4.17
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy SCO 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.18
Reimbursement Policy - *Hospital*, policy number WS 4.21
Reimbursement Policy - *Infertility Services*, policy number 4.34
Reimbursement Policy - *Inpatient Hospital*, policy number 4.110
Reimbursement Policy - *Inpatient Hospital*, policy number SCO 4.110
Reimbursement Policy - *Non-Participating Provider*, policy number WS 4.5
Reimbursement Policy - *Non-Reimbursed Codes*, policy number 4.38
Reimbursement Policy - *Non-Reimbursed Codes*, policy number WS 4.38
Reimbursement Policy - *Outpatient Hospital*, policy number 4.17
Reimbursement Policy - *Outpatient Hospital*, policy number SCO 4.17
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number 4.608
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number SCO 4.608
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number WS 4.28
Reimbursement Policy - *Professional Bilateral and Multiple Procedure Reductions*, policy number WS 4.24
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number 4.610
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number SCO 4.610

Gender Affirmation Surgeries

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Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number 4.29

**Reference to Applicable Laws and Regulations**


130 CMR 450.000. Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations.


MGL ch.175. Massachusetts General Laws. Insurance.


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Disclaimer Information: *

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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