

Medical Policy

Gender Reassignment Surgery

Policy Number: OCA 3.11

Version Number: 7

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Product Applicability

All Plan⁺ Products

Well Sense Health Plan

- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan

- MassHealth
- 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 to determine coverage guidelines for Senior Care Options.

Policy Summary

Gender reassignment surgery is considered medically necessary as one treatment option for a member seeking treatment for gender dysphoria when the Plan’s medical criteria are met, as specified in this Plan policy. Gender reassignment surgery may include more than one (1) surgical procedure and is part of a complex treatment plan involving medical, surgical, and behavioral health interventions to achieve the desired outcomes for the individual. Plan prior authorization is required for gender reassignment surgery. It will be determined during the Plan’s prior authorization process if the procedure is considered medically necessary for the requested indication. See the Massachusetts definition of medical necessity for members enrolled in Qualified Health Plans, ConnectorCare, and/or Employer Choice Direct products (specified in the Definitions section of this Plan policy with applicable source). The Plan will review all requests for breast augmentation for male-to-female (MtF) members

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and mastectomy for female-to-male (FtM) members for gender reassignment 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 reassignment surgery).

See the member's applicable benefit summary document available at www.bmchp.org (or at www.SeniorsGetMore.org for Senior Care Options 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 reassignment surgical procedures. BMC HealthNet Plan members and providers may search the BMC HealthNet Plan formulary for coverage of specific medications and review the list of drugs that require prior authorization; documents are available at <http://www.bmchp.org/pharmacy/providers/pharmacy-programs> (or at www.SeniorsGetMore.org for Senior Care Options 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. See Plan policy, *Clinical Criteria*, policy number OCA 3.201.

Description of Item or Service

Gender Reassignment Surgery: 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.

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,

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Version 7, World Professional Association for Transgender Health (WPATH), 2012. (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.)

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 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 reassignment surgery 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 or at www.SeniorsGetMore.org for a Senior Care Options 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:

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 5:

1. An assessment of the member's gender identity and gender dysphoria resulting in a diagnosis of persistent, well-documented gender dysphoria meeting DSM 5 criteria (as specified in the Definitions section of this Plan policy) by a clinician who has been treating the member and has confirmed the diagnosis of gender dysphoria); AND
2. History and development of the member's gender dysphoric feelings for a minimum of 24 consecutive months, as defined by the DSM 5 criteria for gender dysphoria (as specified in the Definitions section of this policy); AND
3. The impact of stigma attached to gender nonconformity on the member's mental health, including clinically significant distress or impairment; AND
4. 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); AND
5. 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)

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(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 living in the gender role that is congruent with the member's gender identity for a significant period of time (for a minimum of 12 months); AND

C. Member Age:

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

[*Note: Plan Medical Director review is required for gender reassignment 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 WPATH Standards of Care for Health and Transsexual, Transgender, and Gender-Nonconforming People, with review of 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 treatment of an adolescent member may not apply if the adolescent member is emancipated at the time the service is rendered.]

D. Procedure-Specific Criteria by Gender:

Criteria specified above in items A through C and ALL applicable criteria listed below must be met for prior authorization of the specific surgical procedure(s) requested.

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

a. Breast Augmentation for Male-to-Female (MtF) Members:

This policy includes medical criteria for the initial breast augmentation procedure as a component of gender reassignment 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 reassignment surgery).

Augmentation mammoplasty with implantation of breast prostheses is considered medically necessary for male-to-female members with persistent, well-documented gender dysphoria when criteria listed above in items A through C are met and ALL of the following criteria are met for the initial breast augmentation for gender reassignment surgery, as specified below in items (1) through (4):

- (1) 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 DSM 5 criteria; AND
- (2) The treating surgeon, in consultation with the qualified licensed mental health professional who has assessed the member, 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); AND
- (3) 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
- (4) The member has had 24 continuous months of physician-supervised hormone therapy, but the therapy has not resulted in breast development (unless hormone therapy is medically contraindicated for the member); OR

b. 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 criteria listed above in items A through C are met and ALL of the following criteria are met, as specified below in items (1) through (8):

- (1) ONE (1) or MORE of the following procedures will be performed on a member with gender dysphoria, as specified below in items (a) through (f):
 - (a) Clitoroplasty; AND/OR
 - (b) Labiaplasty; AND/OR

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- (c) Orchiectomy; AND/OR
- (d) Penectomy; AND/OR
- (e) Vaginoplasty/colovaginoplasty;[∞] AND/OR

[∞] Plan 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 genital reassignment surgery (e.g., hair removal on skin graft donor site prior to its use for vaginoplasty for MtF members).

- (f) Vulvoplasty; AND
- (2) The treating surgeon is a board certified gynecologist, urologist, plastic surgeon, or general surgeon; AND
 - (3) 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
 - (4) The treating surgeon, in consultation with the qualified licensed mental health professional who has assessed the member, 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
 - (5) 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
 - (6) 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
 - (7) 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); hormone therapy may be concurrent with living in gender role); AND

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- (8) 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; OR

+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 are required and the first referral is from the member's psycho-therapist who has performed the initial assessment, the second referral may be an evaluative consultation, and need not represent an ongoing therapeutic relationship.

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

a. **Bilateral Mastectomy for Female-to-Male (FtM) 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 criteria listed above in items A through C are met and ALL of the following criteria are met, as specified below in items (1) through (3). (Note: Hormone therapy is not a prerequisite for mastectomy with female-to-male members.)

- (1) 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
- (2) The treating surgeon, in consultation with the qualified licensed mental health professional who has assessed the member, 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
- (3) 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

b. **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 criteria listed above in items A through C are met and ALL of the following criteria are met, as specified below in items (1) through (8):

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- (1) ONE (1) or MORE of the following procedures will be performed, as specified below in items (a) through (i):
 - (a) Hysterectomy; AND/OR
 - (b) Metoidioplasty; AND/OR
 - (c) Oophorectomy; AND/OR
 - (d) Phalloplasty with implantation of penile prosthesis;∞ AND/OR
 - ∞ Plan 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 genital reassignment surgery (e.g., hair removal on skin graft donor site prior to its use for phalloplasty for FtM members).
 - (e) Salpingectomy; AND/OR
 - (f) Scrotoplasty with insertion of testicular implants; AND/OR
 - (g) Urethroplasty; AND/OR
 - (h) Vaginectomy; AND/OR
 - (i) Vulvectomy; AND
- (2) The treating surgeon is a board certified gynecologist, urologist, plastic surgeon, or general surgeon; AND
- (3) 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
- (4) The treating surgeon, in consultation with the qualified mental health professional who has assessed the member, 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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- (5) 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
- (6) 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
- (7) 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 hormone therapy may be concurrent with living in gender role; AND
- (8) 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; AND

+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 are required and the first referral 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.

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

Requests for prior authorization for gender reassignment 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 gender reassignment surgery, medical record documentation must show that they are being optimally managed and are reasonably well-controlled; AND

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3. If any significant coexisting medical concerns are identified prior to gender reassignment 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 gender reassignment 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 gender reassignment 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) for gender reassignment surgery(ies) from a qualified licensed mental health professional(s). One (1) referral from a qualified licensed mental health professional is required for mastectomy or augmentation mammoplasty. Two (2) referrals from qualified licensed mental health professionals, who have independently assessed the member, are required for genital surgery. When two (2) referrals are required and the first referral 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. 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 f:
 - 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
 - d. An explanation demonstrating that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery; AND
 - e. A statement that informed consent has been obtained 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
 - f. 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

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7. A letter from the surgeon performing the gender reassignment surgery 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 surgeon believes that it is likely that the procedure will alleviate the member's gender dysphoria; AND
 - c. The surgeon has personally communicated with the qualified licensed mental health professional and any other health care professionals involved in the member's care, including but not limited to the member's primary care physician and the health care professional who is providing feminizing/masculinizing hormone therapy (if applicable); AND
 - d. The 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, the surgeon has discussed procedures for the preservation of fertility with the member prior to surgery; AND
 - f. The member's treating surgeon, as well as the required qualified licensed health provider(s), have documented within three (3) 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 reassignment surgery to be medically necessary when applicable Plan criteria in the Medical Policy Statement section of this policy are NOT met.
2. 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 is experimental or investigational. Like external reviews for other types of medical services and treatments, the external review 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.)

3. Pediatric/Adolescent Members:

When gender reassignment 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 or at www.SeniorsGetMore.org for a Senior Care Options 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 Criteria* policy, policy number OCA 3.201, and must meet ALL applicable Plan criteria for the requested procedure(s), as specified in the Medical Policy Statement section of this policy.

4. Reversal of Gender Reassignment Surgery:

When reversal of gender reassignment surgery 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 or at www.SeniorsGetMore.org for a Senior Care Options member), Plan Medical Director review is required. Requests for reversal of gender reassignment surgery will be reviewed individually by a Plan Medical Director based on the Plan's *Clinical Criteria* policy, policy number OCA 3.201.

5. 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 gender reassignment surgery.

b. Medically Necessary Hair Removal:

Electrolysis and/or laser ablation treatments for hair removal performed by a licensed dermatologist or treating provider may be considered medically necessary for the removal of hair on a skin graft for its use in genital sex reassignment 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).

6. 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:

- 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. Mastopexy (unless medical criteria are met in the Plan medical policy, *Mastopexy*, policy number OCA 3.717 available at www.bmchp.org); OR
- k. Osteoplasty; OR
- l. Pectoral implants; OR
- m. Removal of redundant skin (unless Plan medical criteria are met, as specified in the medical policy, *Panniculectomy and Related Redundant Skin Surgery*, policy number OCA 3.722, available at www.bmchp.org); OR
- n. Rhinoplasty; OR
- o. Rhytidectomy; OR
- p. Silicone injections of the breast; OR

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- q. Skin resurfacing; OR
 - r. Thyroid cartilage reduction; OR
 - s. Voice modification surgery
7. Laparoscopic prostatectomy as a component of gender reassignment surgery requires Plan Medical Director review.
 8. Post-operative lodging is not routinely covered by the Plan; Plan Medical Director review is required for individual consideration.
 9. Reimbursement for travel expenses is NOT covered by the Plan (unless 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).
 10. Voice therapy lessons are not a covered service for gender dysphoria (unless otherwise specified in the member's applicable benefit document available at www.bmchp.org).
 11. Feminizing/masculinizing hormonal therapy and/or gender reassignment surgery may limit the member's fertility. Plan medical criteria for infertility services (covered for some Plan products) are listed in the *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.

See the Massachusetts definition of medical necessity for members enrolled in Qualified Health Plans, ConnectorCare, and/or Employer Choice Direct products (specified in the Definitions section of this Plan policy with applicable source). Review Plan policy, *Cosmetic, Reconstructive, and Restorative Services*, 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.

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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 as part of sex reassignment surgery.

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

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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 does not have a formal law or procedure 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 reassignment surgery.

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: *Diagnostic 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.

Gender Identity (for the Members Enrolled in Qualified Health Plans, ConnectorCare, or Employer Choice Direct Products): 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 minora 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

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 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 reassignment surgery.

Mammoplasty/Mammoplasty: Cosmetic 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 the Members Enrolled in Qualified Health Plans, ConnectorCare, or Employer Choice Direct Products): 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.)

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 semirigid (noninflatable) 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 in phenotypical males (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 female-to-male 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.

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 Commonwealth of Massachusetts; 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; 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 or physical gender.

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 reassignment 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 reassignment surgery 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.

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. For genital sex-reassignment 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.

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 States 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). Because 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 Plan reimbursement policies for Plan billing guidelines.

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ICD-10 Codes	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. Plan note: Gender reassignment 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.
F64.1-F64.9	Gender identity disorders
Z87.890	History of sex reassignment surgery

CPT Codes	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).
19301	Mastectomy partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
53430	Urethroplasty, reconstruction of female urethra Plan note: Procedure may be performed as a component of gender reassignment surgery 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.
54120	Amputation of penis; partial
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; noninflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female Plan note: Series of staged procedures to remove penis and create vagina.

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55980	Intersex surgery; female to male Plan note: Series of staged procedures to remove or close vagina and for penis and testicles.
56625	Vulvectomy, simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy, complete removal of vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy) with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250g or less
58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250g
58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical with vaginal hysterectomy, for uterus greater than 250g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less

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58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure); with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral

CPT Codes	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).
17380	<p>Electrolysis epilation , each 30 minutes</p> <p>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 gender reassignment 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 genital sex reassignment 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).</p>
17999	<p>Unlisted procedure, skin, mucous membrane and subcutaneous tissue</p> <p>Plan notes:</p> <ol style="list-style-type: none"> Code used when billing for laser ablation for hair removal on a skin graft donor site for genital sex reassignment surgery. 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 gender reassignment 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 genital sex reassignment 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).

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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 reassignment surgery. 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 reassignment surgery.

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 reassignment surgery.

Gender reassignment surgery is 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 reassignment surgery; 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 sex-reassignment 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.

For members enrolled in Qualified Health Plans, ConnectorCare, and/or Employer Choice Direct products, the Massachusetts Division of Insurance has determined that denying medically necessary treatment based on an individual's gender identity or gender dysphoria is prohibited sex discrimination under Massachusetts law. Therefore, if medically necessary for the individual patient, carriers must cover treatments for gender dysphoria. See Division of Insurance Bulletin 2014-03, released June 20, 2014.

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

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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 reassignment surgery 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 reassignment surgery based on whether gender reassignment 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 reassignment surgery in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member.

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Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Approved by
Regulatory Approval: N/A Internal Approval: 03/18/15: MPCTAC 04/08/15: QIC	07/01/15 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)	MPCTAC and QIC

*Effective Date for the Senior Care Options Product(s): 01/01/16

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
09/01/15	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.	01/01/16 Version 2	09/16/15: MPCTAC 10/14/15: QIC
11/25/15	Review for effective date 01/01/16. Updated language in the Applicable Coding section.	01/01/16 Version 3	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 08/01/16. Revised the Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Removed ICD9 codes, added CPT code 17380 as applicable code, and added a Plan not in the Applicable Coding section. Revised criteria in the Medical Policy Statement and Limitations sections.	08/01/16 Version 4	04/20/16: MPCTAC 05/23/16: QIC
07/05/16	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.	10/01/16 Version 5	07/05/16: MPCTAC (electronic vote) 07/13/16: QIC

Gender Reassignment Surgery

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Policy Revisions History

09/01/16	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).	10/01/16 Version 6	Not applicable because industry-wide update of CMS guidelines with no change to criteria and/or the applicable code list.
09/28/16	Review for effective date 11/01/16. Administrative changes made to clarify language related to gender. Revised Definitions section.	11/01/16 Version 7	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC

Last Review Date

09/28/16

Next Review Date

04/01/17

Authorizing Entity

QIC

Other Applicable Policies

Administrative Policy - *Clinical Criteria*, policy number OCA 3.201
 Medical Policy - *Ambulance and Transportation Services*, policy number OCA 3.191
 Medical Policy - *Breast Reduction Mammoplasty*, policy number OCA 3.44
 Medical Policy - *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69
 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 - *Anesthesia*, policy number 4.103
 Reimbursement Policy - *Bilateral and Multiple Procedure Reductions*, policy number 4.607
 Reimbursement Policy - *Free Standing Surgical Facility Services*, policy number 4.114
 Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31

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Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number WS 4.31
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108
Reimbursement Policy - *Infertility Services*, policy number 4.34
Reimbursement Policy - *Inpatient Hospital*, policy number 4.110
Reimbursement Policy - *Outpatient Hospital*, policy number 4.17
Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number 4.608

Reference to Applicable Laws and Regulations

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Gender Reassignment Surgery

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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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