



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

| Medical Necessity Guideline (MNG) Title: Gender Affirming Surgery and Related Procedures | | |
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| MNG #: 054 | <input checked="" type="checkbox"/> CCA Senior Care Options (HMO D-SNP) (MA) <input checked="" type="checkbox"/> CCA One Care (Medicare-Medicaid) (MA) | Prior Authorization Needed? <input checked="" type="checkbox"/> Yes (always required) <input type="checkbox"/> Yes (only in certain situations. See this MNG for details) <input type="checkbox"/> No |
| Benefit Type: <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid | Original Approval Date: 3/4/21 | Effective Date: 05/22/2021; 1/1/25; 7/1/25 |
| Last Revised Date: 09/09/2021; 10/14/2021; 6/2/2022; 3/9/2023; 8/8/24; 2/13/25 | Next Annual Review Date: 3/4/2022; 09/09/2022; 10/14/2022; 6/2/2023; 3/9/2024; 8/8/25 | Retire Date: |

OVERVIEW: Gender nonconformity describes an individual's marked and persistent experience of an incompatibility between that individual's gender identity and the gender expected of them based on their birth-assigned sex to the extent to which a person's gender identity, role or expression differs from the cultural norms prescribed for people of a particular gender. Gender dysphoria (GD) refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that which is physically and/or socially attributed to their sex assigned at birth. Not all gender nonconforming individuals will experience GD in their lives. Not all transgender and gender diverse individuals experience gender dysphoria. Gender dysphoria is manifested in a variety of ways including strong desires to be treated consistently with one's gender identity and not by their biological sex or to be rid of one's sex characteristics. Gender affirming surgery (GAS), also known as sexual reassignment surgery or gender confirmation surgery, refers to one or more reconstruction procedures and typically includes multidisciplinary treatment decision making regarding medical, surgical and behavioral health interventions available for the treatment of gender dysphoria. Gender assignment surgery results in a change in an individual's primary and/or secondary sex characteristics to affirm their gender identity and align their body with their gender identity. Individuals considering GAS should demonstrate the capacity to consent for the specific gender-affirming surgical intervention(s). GAS is not meant to be used as a cosmetic procedure to improve one's appearance. This is an important principal in evaluating the medical necessity of members.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) may cover gender affirming surgery and related procedures when the following criteria are met:

1. The member has the capacity to make fully informed decisions and has consented to the requested procedure(s) after limitations, risks, and complications of the procedure have been discussed; and
2. Co-morbid medical and/or behavioral health conditions are appropriately managed, reasonably controlled,



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

and not causing symptoms of gender dysphoria; **AND**

3. Clinical coverage criteria below applicable to requested procedure(s) are met.

A. Masculinization Gender-Affirming Surgery

1. Bilateral mastectomy, reduction mammoplasty, and chest reconstruction/contouring may be covered for female-to-male members when **ALL** of the following criteria are met and documented:

- a. The member has been assessed by a licensed qualified behavioral health professional, resulting in a diagnosis of gender dysphoria (GD) that meets the DSM-5 Criteria; and
 - i. This diagnosis must have been present for at least six months; and
- b. This licensed qualified behavioral health professional recommends the specific procedure(s) being requested for the member.

2. The masculinization gender-affirming surgeries listed below may be covered when **ALL** of the following criteria are met and documented:

Hysterectomy
Salpingo-oophorectomy
Vulvectomy
Vaginectomy
Urethroplasty
Metoidioplasty (micropenis) OR phalloplasty (allows coital ability and standing micturition)
Scrotoplasty with insertion of testicular prothesis
Electrolysis or laser hair removal performed by a licensed qualified professional for the removal of hair on a skin graft donor site prior to its use in genital gender-affirming surgery

- a. The member has been assessed by **TWO** independently licensed qualified health professionals, with each assessment resulting in a diagnosis of GD that meets the DSM-5 criteria; and
 - i. One of the two licensed health professionals must be a licensed qualified behavioral health professional while the other clinician is familiar with the member's health; and
 - ii. The diagnosis (from one of the professionals) must have been present for at least six months; and
- b. Both of these independently qualified licensed health professionals recommend the specific procedure(s) being requested for the member; and



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

- c. The member has had 6 continuous months of clinician-supervised hormone therapy appropriate to their gender goals, unless hormone therapy is medically contraindicated.

B. Feminization Gender-Affirming Surgery

1. Augmentation mammoplasty with implantation of breast prostheses may be covered when **ALL** of the following criteria are met and documented:

- a. The member has been assessed by a licensed qualified behavioral health professional, resulting in a diagnosis of GD that meets the DSM-5 criteria; and
 - i. This diagnosis must have been present for at least six months; and
- b. This licensed qualified behavioral health professional recommends the specific procedure(s) being requested for the member; and
- c. The member has had 6 months of clinician-supervised hormone therapy that resulted in no or minimal breast development, unless hormone therapy is medically contraindicated.

2. The feminization gender-affirming surgeries listed below may covered when **ALL** of the following criteria are met and documented:

Penectomy

Clitoroplasty

Colovaginoplasty

Vulvoplasty

Labiaplasty

Orchiectomy

Electrolysis or laser hair removal performed by a licensed qualified professional for the removal of hair on a skin graft donor site prior to its use in genital gender-affirming surgery

- a. The member has been assessed by **TWO** independently licensed qualified health professionals, with each assessment resulting in a diagnosis of GD that meets the DSM-5 Criteria; and
 - i. One of the two licensed health professional must be a licensed qualified behavioral health professional while the other clinician is familiar with the member's health; and
 - ii. The diagnosis (from one of the professionals) must have been present for at least six months; and
- b. Both of these independently qualified licensed health professionals



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

- recommend the specific procedure(s) being requested for the member; and
- c. The member has had 6 continuous months of clinician-supervised hormone therapy appropriate to their gender goals, unless hormone therapy is medically contraindicated.

C. Facial Feminization or Masculinization

1. The facial feminization or masculinization procedures listed below may be covered when **ALL** of the criteria are met and documented:

- Blepharoplasty (in conjunction with other facial feminization procedures)
- Brow lift
- Cheek augmentation
- Forehead contouring and reduction
- Genioplasty
- Hairline advancement
- Lateral canthopexy
- Lip lift
- Lysis intranasal synechia
- Osteoplasty
- Rhinoplasty and septoplasty
- Suction-assisted lipectomy
- Tracheoplasty
- Facial fat pad procedure

- a. The member has been assessed by a licensed qualified behavioral health professional, resulting in a diagnosis of GD that meets the DSM-5 Criteria.
 - i. This diagnosis must have been present for at least six months.
- b. This licensed qualified behavioral health professional recommends the specific procedure(s) being requested for the member.

2. Hair removal of the face and/or neck by electrolysis or laser hair removal as part of treatment for GD may be



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

covered when **ALL** of the criteria are met and documented:

- a. The member has been assessed by a licensed qualified behavioral health professional, resulting in a diagnosis of GD that meets the DSM-5 criteria.
 - i. This diagnosis must have been present for at least six months.
- b. This licensed qualified behavioral health professional recommends the specific procedure being requested for the member.
- c. The hair removal is restricted to the face and neck.
- d. The member has had 6 continuous months of clinician-supervised hormone therapy appropriate to their gender goals, unless hormone therapy is medically contraindicated.

Documentation required:

- A. Requests for authorization for GAS must be submitted by the surgeon or provider performing the procedure. It must be accompanied by clinical documentation that supports the medical necessity for the procedure, including, but not limited to, the assessment made by the licensed qualified behavioral health professional(s) resulting in a diagnosis of GD, and the referral(s) for surgery from the qualified licensed qualified health professional(s). Documentation of medical necessity must include all of the following:

1. A copy of the assessment(s) performed by the licensed qualified health professional(s), including the date of onset and the history resulting in a diagnosis of GD that meets the DSM-5 Criteria, and referral(s) for the specific procedures, as outlined in the clinical coverage criteria.
 - a. A referral from **ONE** licensed qualified behavioral health professional is required for mastectomy, reduction mammoplasty, chest reconstruction/contouring, augmentation mammoplasty, blepharoplasty, brow lift, cheek augmentation, forehead contouring/reduction, genioplasty, hairline advancement, lateral canthopexy, lip lift, lysis intranasal synechia, osteoplasty, rhinoplasty and septoplasty, suction-assisted lipectomy, and tracheoplasty.
 - b. Referrals from **TWO** licensed qualified health professionals, one of whom must be a licensed qualified behavioral health professional while the other may be a clinician familiar with the member's health, are required for hysterectomy, salpingectomy, oophorectomy, vulvectomy, vaginectomy, penectomy, urethroplasty, orchiectomy, genital reconstructive surgery, clitoroplasty, colovaginoplasty, vulvoplasty, labiaplasty, electrolysis and laser hair removal.
 - c. Each referral must be provided in the form of a letter and include a description of the clinical

Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

rationale for the requested surgery.

2. Documentation (in the form of progress notes) that describe the management and symptom control of any co-existing behavioral health and/or medical conditions.
3. If hormone therapy is a required criterion, the member's medical records must document:
 - a. Patient compliance with the prescribed regimen; and
 - b. Patient's clinical response over the course of the hormone therapy.
4. A letter from the surgeon performing the GAS that must attest to all of the following:
 - a. The member meets the clinical coverage criteria for requested procedure(s); and
 - b. The surgeon has collaborated with the qualified health professional(s) and any other healthcare provider involved in the member's care, including, but not limited to, the member's primary care physician and the healthcare professional who is providing feminization/masculinization hormone therapy (if applicable); and
 - c. The surgeon has discussed the risks and complications of the proposed surgery, including the surgeon's own complication rates, and has obtained informed consent from the member; and
 - d. The surgeon has discussed with the member prior to surgery preservation of fertility and the member understands that these procedures are not covered by MassHealth. Any surgery resulting in sterilization must meet all the applicable state and federal laws, regulations, and guidance.

LIMITATIONS/EXCLUSIONS:

In accordance with MassHealth guidance, CCA presumes that certain procedures and surgeries are not medically necessary for the treatment of GD. Examples of such procedures and surgeries include, but are not limited to, the following:

- Chemical peels
- Collagen injections
- Dermabrasion
- Hair transplantation
- Pectoral, calf, or gluteal implants
- Isolated blepharoplasty
- Lip reduction or enhancement
- Neck lift
- Panniculectomy or abdominoplasty
- Reversal of previous GAS



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

- Revisions of previous GAS other than for complications (infections or impairment or impairment of function)
 - Rhytidectomy
 - Vocal cord surgery
- Fertility procedures are not covered by CCA. Surgeon should discuss with member the effect of specific gender-affirming surgical interventions on reproduction.
 - Surgical procedures performed for cosmetic purposes only are not covered by CCA.

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

| CPT Code | Code Description |
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| 11960 | Insertion of tissue expander(s) for other than breast, including subsequent expansion |
| 11970 | Replacement of tissue expander with permanent implant |
| 11971 | Removal of tissue expander without insertion of implant |
| 14040 | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less |
| 14041 | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm |
| 15769 | Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia) |
| 15771 | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate |
| 15772 | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) |
| 15773 | Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate |
| 15774 | Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure) |
| 15820 | Blepharoplasty, lower eyelid |
| 15821 | Blepharoplasty, lower eyelid; with extensive herniated fat pad |
| 15822 | Blepharoplasty, upper eyelid |
| 15823 | Blepharoplasty, upper eyelid; with excessive skin weighting down lid |
| 15876 | Suction assisted lipectomy; head and neck |
| 15877 | Suction assisted lipectomy; trunk |
| 15878 | Suction assisted lipectomy; upper extremity |
| 15879 | Suction assisted lipectomy; lower extremity |
| 17380 | Electrolysis epilation, each 30 minutes |
| 17999 | Unlisted procedure, skin, mucous membrane and subcutaneous tissue |
| 19303 | Mastectomy, simple, complete |
| 19316 | Mastopexy |



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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| 19318 | Breast reduction |
| 19325 | Breast augmentation with implant |
| 19350 | Nipple/areola reconstruction |
| 21120 | Genioplasty; augmentation (autograft, allograft, prosthetic material) |
| 21121 | Genioplasty; sliding osteotomy, single piece |
| 21122 | Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin) |
| 21123 | Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) |
| 21125 | Augmentation, mandibular body or angle; prosthetic material |
| 21127 | Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft) |
| 21137 | Reduction forehead; contouring only |
| 21138 | Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft) |
| 21139 | Reduction forehead; contouring and setback of anterior frontal sinus wall |
| 21172 | Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts) |
| 21175 | Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts) |
| 21179 | Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material) |
| 21180 | Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts) |
| 21208 | Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) |
| 21209 | Osteoplasty, facial bones; reduction |
| 21270 | Malar augmentation, prosthetic material |
| 21282 | Lateral canthopexy |
| 30400 | Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip |
| 30410 | Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip |
| 30420 | Rhinoplasty, primary; including major septal repair |
| 30430 | Rhinoplasty, secondary; minor revision (small amount of nasal tip work) |
| 30435 | Rhinoplasty, secondary; intermediate revision (bony work with osteotomies) |
| 30450 | Rhinoplasty, secondary; major revision (nasal tip work and osteotomies) |
| 30560 | Lysis intranasal synechia |
| 31599 | Unlisted procedure, larynx |
| 31750 | Tracheoplasty; cervical |
| 53410 | Urethroplasty, 1-stage reconstruction of male anterior urethra |
| 53415 | Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra |
| 53420 | Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage |

Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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| 53425 | Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage |
| 53430 | Urethroplasty, reconstruction of female urethra |
| 54125 | Amputation of penis; complete |
| 54400 | Insertion of penile prosthesis; non-inflatable (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 |
| 54690 | Laparoscopy, surgical; orchiectomy |
| 55175 | Scrotoplasty; simple |
| 55180 | Scrotoplasty; complicated |
| 55899 | Unlisted procedure, male genital system (when specified as metoidioplasty or phalloplasty with penile prosthesis) |
| 55970 | Intersex surgery; male to female |
| 55980 | Intersex surgery; female to male |
| 56620 | Vulvectomy simple; partial |
| 56625 | Vulvectomy simple; complete |
| 56800 | Plastic repair of introitus |
| 56805 | Clitoroplasty for intersex state |
| 56810 | Perineoplasty, repair of perineum, non-obstetrical (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 250 g or less; |
| 58262 | Vaginal hysterectomy, for uterus 250 g 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 250 g |
| 58291 | Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58541 | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less |
| 58542 | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with |



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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| | removal of tube(s) and/or ovary(s) |
| 58543 | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g |
| 58544 | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58550 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less |
| 58552 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |
| 58553 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g |
| 58554 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58570 | Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less |
| 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 250 g |
| 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 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 |
| 67900 | Repair of brow ptosis (supraciliary, mid-forehead or coronal approach) |

Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual® criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity [supporting literature (full text preferred) should be attached to the request], or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

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Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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REVISION LOG:

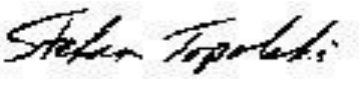
| REVISION DATE | DESCRIPTION |
|---------------|---|
| 2/13/25 | For effective date July 1, 2025, added CPT codes 21172, 21175, 21179, 21180. |
| 1/1/25 | Template and product update |
| 8/8/2024 | Hormone replacement requirement decreased from 12 to 6 months, and requirement to live as gender congruent with identity removed. Cosmetic and fertility limitations added. Coding updated: removed CPT 54660, covered without prior authorization. For effective date 1/1/2025, added CPT codes to be covered with prior authorization: 11960, 14040, 14041, 15769, 15771, 15772, 15773, 15774, 15877, 15878, 15879, 21125, 21127, 21208, 58275. |
| 12/31/23 | Utilization Management Committee approval |
| 6/2/2022 | Template update. |




Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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| 09/09/2021 | Updated based on MassHealth Bulletin release and Rhode Island Medicaid PA review |
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APPROVALS:

| | |
|---|------------------|
| Stefan Topolski | Medical Director |
| CCA Clinical Lead | Title |
|  | 2/13/25 |
| Signature | Date |
| | |
| CCA Senior Operational Lead | Title |
| | |
| Signature | Date |

| | |
|---|-----------------------|
| Nazlim Hagmann | Chief Medical Officer |
| CCA CMO or Designee | Title |
|  | 2/13/25 |
| Signature | Date |