



Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Gender Affirming Surgery and Related Procedures		
MNG #: 54	<input checked="" type="checkbox"/> SCO <input checked="" type="checkbox"/> One Care <input checked="" type="checkbox"/> MAPD-MA Medicare Preferred <input checked="" type="checkbox"/> MAPD-MA Medicare Value <input checked="" type="checkbox"/> MAPD-RI Medicare Preferred <input checked="" type="checkbox"/> MAPD-RI Medicare Value <input checked="" type="checkbox"/> DSNP-RI Medicare Maximus	Prior Authorization Needed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Clinical: <input checked="" type="checkbox"/>	Operational: <input type="checkbox"/>	Informational: <input type="checkbox"/>
Medicare Benefit: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Approval Date: 3/4/2021	Effective Date: 05/22/2021
Last Revised Date: 09/09/2021; 10/14/2021	Next Annual Review Date: 3/4/2022; 09/09/2022; 10/14/2022	Retire Date:

OVERVIEW: Gender nonconformity refers 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 person’s sex at birth. Only some gender nonconforming people will experience GD in their lives. GD 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 that may be part of a multidisciplinary treatment plan involving medical, surgical and behavioral health interventions available for the treatment of GD. The purpose of GAS is to therapeutically treat GD, and to better align one’s physical characteristics with one’s gender identity. GAS is not meant to be used as a cosmetic procedure to improve a person’s appearance. This is an important principle in evaluating the medical necessity of members.

DECISION GUIDELINES:

Commonwealth Care Alliance (CCA) will consider approval for coverage of gender reassignment and related procedures, including those listed as non-covered, on an individual case-by-case basis in accordance with 130 CMR 433.00: Physician Services and 130 CMR 450.204: Medical Necessity. Each case will be reviewed by a CCA medical director.

Clinical Eligibility:

A. Masculinizing Gender-Affirming Surgeries

1. Bilateral mastectomy, reduction mammoplasty, and chest reconstruction/contouring may be considered medically necessary for female-to-male members when **ALL** of the following criteria, listed in subsections



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A.1.a through A.1.c., 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-V Criteria.
 - This diagnosis must be present for at least six months.
- b. The licensed qualified behavioral health professional described in A.1.a, above, recommends the specific procedure(s) for the member.
- c. If significant co-morbid medical or behavioral health conditions are appropriately managed, reasonable controlled, and not causing symptoms of GD.

2. The masculinizing gender-affirming (transmale) surgeries listed below may be medical necessary when **ALL** of the criteria, listed in subsections A.2.a through A.2.f., 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-V criteria.
 - One of the two licensed health professionals must be a licensed qualified behavioral health professional while the other may be a clinician that is familiar with the member's health.
 - The initial diagnosis (from one of the professionals) must have been present for at least six months.
 - b. Both independently qualified licensed health professionals, noted in Section A.2.a. above, recommend the specific procedure(s) for the member.
 - c. The member is 18 years of age or older.
 - d. Co-morbid medical and/or behavioral health conditions are appropriately managed, reasonably controlled, and not causing symptoms of GD.
 - e. The member has had 12 continuous months of living as the gender that is congruent with their identity.
 - Exceptions may be considered on a case-by-case basis should the request document that in compliance with this requirement, it would jeopardize the health, safety, or well-being of the member.



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- f. The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the their gender goals, unless hormone therapy is medically contraindicated (this period of hormone therapy may be concurrent with the requirement set forth in subsection A.2.e).

B. Feminizing Gender-Affirming Surgeries

1. Augmentation mammoplasty with implantation of breast prostheses may be considered medically necessary when **ALL** of the following criteria, listed in subsections B.1.a through B.1.e., 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-V criteria.
 - This diagnosis must have been present for at least six months.
 - b. The licensed qualified behavioral health professional described in subsection B.1.a., above, recommends the specific procedure(s) for the member.
 - c. The member is 18 years of age or older.
 - d. Co-morbid medical and/or behavioral health conditions are appropriately managed, reasonably controlled, and not causing symptoms of GD.
 - e. The member has had 12 months of clinician-supervised hormone therapy that resulted in no or minimal breast development, unless hormone therapy is medically contraindicated.
2. The feminizing gender-affirming (transfemale) surgeries listed may be medical necessary when **ALL** of the criteria listed in subsections B.2.a. through B.2.f., below, 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 GAS
 - 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-V Criteria.
 - One of the two licensed health professional must be a licensed qualified behavioral health professional while the other may be a clinician that is familiar with the member's health.
 - The initial diagnosis (from one of the professionals) must have been present for at least sixmonths.
 - b. Both independently qualified licensed health professional noted in subsection B.2.a. above, recommend the specific procedure(s) for the member.
 - c. The member is 18 years of age or older.
 - d. Co-morbid medical and/or behavioral health conditions are appropriately managed, reasonably controlled, and not causing symptoms of GD.
 - e. The member has had 12 continuous months of living as the gender that is congruent with their identity.



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- Exceptions may be considered on a case-by-case basis should the request document that in compliance with this requirement, it would jeopardize the health, safety, or well-being of the member.
- f. The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to their gender goals, unless hormone therapy is medically contraindicated (this period of hormone therapy may be concurrent with the requirement set forth in subsection B.2.e).

C. Facial Feminization or Masculinization

1. The facial feminization or masculinization procedures listed below may be medically necessary when **ALL** of the criteria listed in subsections C.1.a. through C.1.d, below 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

- a. The member has been assessed by **A** licensed qualified behavioral health professional, resulting in a diagnosis of GD that meets the DSM-V Criteria.
 - The initial diagnosis must have been present for at least six months.
 - b. The licensed qualified behavioral health professional noted in subsection C.2.a., above, recommends the specific procedure(s) for the member.
 - c. The member is 18 years of age or older.
 - d. Co-morbid medical and/or behavioral health conditions are appropriately managed, reasonably controlled, and not causing symptoms of GD.
2. Hair removal of the face and/or neck by electrolysis or laser hair removal as part of treatment for GD may be considered medically necessary when **ALL** of the criteria listed in subsections C.2.a through C.2.g., below 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-V criteria.
 - This diagnosis must be present for at least six months.
 - b. The licensed qualified behavioral health professional described in subsection C.2.a., above recommends the specific procedure for the member.



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- c. The hair removal is restricted to the face and neck.
- d. The member is 18 years of age or older.
- e. The member has the capacity to make fully informed decisions and has consented to the procedure after limitations, risks, and complications of the procedure have been discussed.
- f. Co-morbid medical and/or behavioral health conditions are appropriately managed, reasonably controlled, and not causing symptoms of GD.
- g. The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the their gender goals, unless hormone therapy is medically contraindicated.

Determination of need: As above

Documentation:

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-V Criteria, and referral(s) for the specific procedures, as outlined in the clinical guideline.
 - 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 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 living as the gender that is congruent with the member's identity is a required criterion, the member's medical records must document:
 - a. The date the member started living as this gender; and



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- b. The member's experience living as this gender.
4. 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.
5. A letter from the surgeon performing the GAS that must attest to all of the following:
 - a. The member meets the clinical criteria for coverage described in Section A, B, and C outlined in the Decision Guidelines;
 - 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 feminizing/masculinizing hormone therapy (if applicable);
 - 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 about 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
- Revisions of previous GAS other than for complications (infections or impairment or impairment of function)
- Rhytidectomy
- Vocal cord surgery

KEY CARE PLANNING CONSIDERATIONS:

N/A



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AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. 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. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. 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).

CPT Code	Description
Gender-Affirming Surgeries	
17380	Electrolysis epilation, each 30-minutes (when done to treat tissue donor sites for a phalloplasty or vaginoplasty procedure)
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue (when specified as hair removal by laser to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure)
19303	Mastectomy, simple, complete
19318	Reduction mammoplasty
19324-19325	Mammoplasty, augmentation
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopic, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
55899	Unlisted procedure, male genital system (when specified as metoidioplasty or phalloplasty with penile prosthesis)
55970	Intersex surgery; male to female (a series of staged procedures that includes male genitalia removal, penile dissection, urethral transposition, creation of vagina and labia with stent placement)



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55980	Intersex surgery; Female to male (a series of staged procedures that include penis and scrotum formation by graft, and prostheses placement)
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, non-obstetrical (separate procedure)
57106-57107, 57110-57111	Vaginectomy, partial removal of vaginal wall; complete removal of vaginal wall
57291-57292	Construction of artificial vagina, with or without graft
57335	Vaginoplasty for intersex state
58150, 58180, 58260-58262, 58275-58291, 58541-58544, 58550-58554	Hysterectomy
58570-58573	Laparoscopy, surgical, with total hysterectomy
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral
Facial Feminization or Masculinization Procedures	
15820-15823	Blepharoplasty (when performed in conjunction with other feminization procedures)
15876	Suction-assisted lipectomy; head and neck
21120-21123	Genioplasty
21137-21139	Reduction forehead; contouring
21270	Malar augmentation, prosthetic material
21208-21209	Osteoplasty, facial bones
21280, 21282	Canthopexy
30400	Rhinoplasty, primary; lateral and alar cartilage 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
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30560	Lysis intranasal synechia
30620	Septal or other intranasal dermatoplasty
31750	Tracheoplasty; cervical
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

REGULATORY NOTES:

1. MassHealth Guidelines for Medical Necessity Determination for Gender-Affirming Surgery (MNG-GAS 09/21)



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2. MassHealth Guidelines for Medical Necessity Determination for Hair Removal (MNG-HR 09/21)
3. Rhode Island Medicaid Prior Approval (PA) Criteria for Surgical Procedures: Gender Dysphoria/Gender Nonconformity Coverage Guidelines

Disclaimer:

This Medical Necessity Guideline is not a rigid rule. As with all of 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.

RELATED REFERENCES:

1. The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. 7th Version.
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013, pp 451-459.
3. Hembree WC, Cohen-Kettenis HA, Delmarre-van de Waal, et al. Endocrine Treatment of Transexual Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2009;94:3132-54.
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10. Ainsworth TA, Spiegel JH. Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. Qual Life Res. 2010 Sep; 19(7):1019-24. Doi: 10.1007/s11136-010-9668-7. Epub 2010 May 12.
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- 12. Roberts T, Bruce V. Feature saliency in judging the sex and familiarity of faces. Perception 1988; 17: 475-481.
- 13. Bellinga RJ, Capitan L, Simon d, Tenorio T. Technical and Clinical Considerations for Facial Feminiazation Surgery with Rhinoplasty and Related Procedures. JAMA Facial Plastic Surgery.2017; 19 (3): 175-181.
Doi:10.1001/jamafacial.2016.1572
- 14. Becking AG, Tuinzing DB, Hage J, Gooren LJG. Transgender Feminization of the Facial Skeleton. Clinics in Plastic Surgery. 2007; 34 (3): 557-564.

ATTACHMENTS:

EXHIBIT A	
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REVISION LOG:

REVISION DATE	DESCRIPTION
09/09/2021	Updated based on MassHealth Bulletin release and Rhode Island Medicaid PA review



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3/4/2021

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