Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Gender Affirming Surgery and Related Procedures		
MNG #: 054	**☒CCA Senior Care Options (HMO D-SNP) (MA)** **☒CCA One Care (Medicare-Medicaid) (MA)**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Benefit Type: **☒ Medicare** **☒ Medicaid**	**Original Approval Date:** 3/4/21	**Effective Date:** 05/22/2021; 1/1/25
Last Revised Date: 09/09/2021; 10/14/2021; 6/2/2022; 3/9/2023; 8/8/24	**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, and not causing symptoms of gender dysphoria; **AND**

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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

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

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

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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 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:

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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

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- 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
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 defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands 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 injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs 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, 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, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code fo 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

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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 a
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
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
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

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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 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)

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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

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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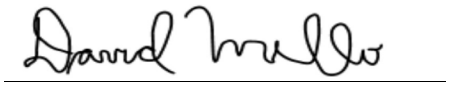
REVISION LOG:

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

APPROVALS:

David Mello	Senior Medical Director Utilization Review and Medical Policy
CCA Clinical Lead	**Title**
	8/8/24
Signature	**Date**
CCA Senior Operational Lead	**Title**
Signature	**Date**

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Nazlim Hagmann	Chief Medical Officer
CCA CMO or Designee	**Title**
	8/8/24
Signature	**Date**