Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Gender Affirming Surgery and Related Procedures		
MNG #: 54	**☒SCO ☒One Care**	**Prior Authorization Needed? ☒Yes ☐No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Medicare Benefit: ☒Yes ☐No	**Approval Date:** 3/4/2021	**Effective Date:** 05/22/2021
Last Revised Date:	**Next Annual Review Date:** 03/04/2022	**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 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 essential purpose of GAS is to therapeutically treated GD, not to improve a person's appearance. Simply stated, the purpose of GAS is to better align one's physical characteristics with one's gender identity. It is not meant to extend to cosmetic procedure. 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 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. Female-to- Male Gender-Affirming (Transmale) Surgeries

1. Bilateral mastectomy may be considered medically necessary for female-to-male members when **ALL** of the following criteria are met:

a. Assessment performed by **a** Qualified Mental Health Professional resulting in a diagnosis of gender dysphoria (GD) meeting DSM-V Criteria; this diagnosis must be present for at least six months.

b. The qualified mental health professional described in 1.a, above, recommends bilateral mastectomy for the member.
c. Capacity to make a fully informed decision and consent for treatment has been granted after limitations, risks, and complications of the procedure have been discussed.
d. The member is 18 years of age or older.
e. If significant co-morbid medical or mental health concerns are present, they are being optimally managed, reasonably well controlled, and not causing symptoms of dysphoria.

2. Female-to-male gender-affirming (transmale) surgeries listed below may be medical necessary when **ALL** of the criteria listed in subsections 2.a-g are met and documented:

- Hysterectomy
- Salpingo-oopherectomy
- Vulvectomy
- Vaginectomy
- Urethroplasty
- Metoidoplasty (micropenis) OR phalloplasty (allows coital ability and standing micturition)
- Scrotoplasty with insertion of testicular prothesis
- Electrolysis performed by a licensed dermatologist 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** independent qualified mental health professionals, resulting in a diagnosis of GD meeting DSM-V criteria from both qualified mental health professionals; the initial diagnosis must have been present for at least six months.
b. Both qualified mental health professionals noted in Section 2.a, above, recommend the specific procedure(s) for the member.
c. The member is 18 years of age or older.
d. The member has capacity to make fully informed decisions and has consented to the procedure after limitations, risks, and complications of the procedure have been discussed.
e. Co-morbid medical and/or mental health disorders are appropriately managed, reasonably controlled, and not causing symptoms of dysphoria.
f. The member has had 12 continuous months of living as the gender that is congruent with the member's identity.
g. The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated (this period of hormone therapy may be concurrent with the requirement set forth in subsection 2.f).

B. Male-to-Female Gender-Affirming (Transfemale) Surgeries

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1. Augmentation mammoplasty with implantation of breast prostheses may be considered medically necessary when **ALL** of the following criteria are met:

a. The member has been assessed by **a** qualified mental health professional, resulting in a diagnosis of GD meeting DSM-V criteria; this diagnosis must have been present for at least 6 months.
b. The qualified mental health professional described in subsection 3.a, above, recommends the specific procedure for the member.
c. The member is 18 years of age or older.
d. The member has capacity to make fully informed decisions and has consented to the procedure after limitations, risks, and complications of the procedure have been discussed.
e. Co-morbid medical and/or mental health disorders are appropriately managed, reasonably controlled, and not causing symptoms of dysphoria.
f. 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 male-to-female gender-affirming (transfemale) surgeries listed may be medical necessary when **ALL** of the criteria listed in subsections B.a-g, below, are met and documented.

- Penectomy
- Clitoroplasty
- Colovaginoplasty
- Vulvoplasty
- Labiaplasty
- Orchiectomy.

a. The member has been assessed by **TWO** independent qualified mental health professionals, resulting in a diagnosis of GD meeting DSM-V Criteria from both qualified mental health professionals; the initial diagnosis must have been present for at least six months.
b. Both qualified mental health professionals noted in subsection 2.a, above, recommend the specific procedure(s) for the member.
c. The member is 18 years of age or older.
d. The member has capacity to make fully informed decisions and has consented to the procedure after limitations, risks, and complications of the procedure have been discussed.
e. Co-morbid medical and/or mental health disorders are appropriately managed, reasonably controlled, and not causing symptoms of dysphoria.
f. The member has had 12 continuous months of living as the gender that is congruent with the member's identity.
g. The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated (this period of hormone therapy may be concurrent with the requirement set forth in subsection 2.f).

C. **Facial Feminization or Masculinization**

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The procedures listed below may be medically necessary when **ALL** of the criteria listed in subsections C.a-e, below, are met and documented.

- Tracheoplasty
- Forehead contouring
- Brow lift
- Blepharoplasty (in conjunction with other facial feminization procedures)
- Cheek augmentation
- Rhinoplasty
- Suction-assisted lipectomy
- Genioplasty

a. The member has been assessed by **TWO** independent qualified mental health professionals, resulting in a diagnosis of GD meeting DSM-V Criteria from both qualified mental health professionals; the initial diagnosis must have been present for at least six months.
b. Both qualified mental health professionals noted in subsection 2.a, above, recommend the specific procedure(s) for the member.
c. The member is 18 years of age or older.
d. The member has capacity to make fully informed decisions and has consented to the procedure after limitations, risks, and complications of the procedure have been discussed.
e. Co-morbid medical and/or mental health disorders are appropriately managed, reasonably controlled, and not causing symptoms of dysphoria.

Determination of need: As above

Documentation:

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

1. A copy of the assessment performed by qualified mental health professional(s), including date of onset and history resulting in a diagnosis of GD meeting DSM-V Criteria and referral(s) for the specific procedures, as outlined in clinical guidelines.
   a. A referral from one qualified mental health professional is required for mastectomy or augmentation mammoplasty.
   b. Referrals from two qualified mental health professionals, who have independently assessed the member, are required for hysterectomy, salpingectomy, oophorectomy, vulvectomy, vaginectomy, penectomy, orchietomy, and genital reconstructive surgery.

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c. Each referral must be provided in the form of a letter and include description of the clinical rationale for the requested surgery.

2. Progress notes documenting that any co-existing mental health issues or medical issues are being appropriately managed and are reasonably controlled.

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

b. The member's experience living as this gender.

4. If hormone therapy is a required criterion, medical records must document patient compliance with the prescribed regimen and clinical response over the course of hormone therapy.

5. A letter from the surgeon performing the GAS must attest to all of the following:

a. The member meets the clinical criteria for coverage described in Section II.A. of these Guidelines; and

b. The surgeon has collaborated with the qualified mental health professional(s) and any other health care professionals involved in the member's care, including, but not limited to, the member's primary care clinician and the health care professional who is providing feminizing/masculinizing hormone therapy (if applicable); and

c. The surgeon has discussed risks and complications of the proposed surgery, including the surgeon's own complication rates, and has obtained informed consent from the member.

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 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:

- Reversal of previous GAS
- Revisions of previous GAS other than for complications (infections or impairment or impairment of function)
- Neck lift
- Collagen injections
- Dermabrasion
- Chemical peels
- Hair transplantation
- Lip reduction or enhancement

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- Panniculectomy or abdominoplasty is not covered for gender dysphoria
- Voice modification therapy or surgery
- Pectoral, calf, or gluteal implants
- Isolated blepharoplasty is not covered for gender dysphoria

KEY CARE PLANNING CONSIDERATIONS:
N/A

AUTHORIZATION:

REGULATORY NOTES:
MassHealth Guidelines for Medical Necessity Determination for Gender-Affirming Surgery (MNG-GAS 07/19)

RELATED REFERENCES:

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14. Becking AG, Tuinzing DB, Hage J, Gooren LJG. Transgender Feminization of the Facial Skeleton. Clinics in Plastic Surgery. 2007; 34 (3): 557-564.

EXHIBIT A	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION

Peggy Johnson MD
CCA Senior Clinical Lead [Print]

VP & Chief of Psychiatry
Title [Print]

Signature

3/4/2021
Date

Doug Hsu, MD
CCA Senior Operational Lead [Print]

VP, Medical Policy & Utilization Review
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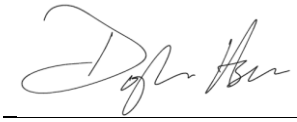	3/4/2021
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Lori Tishler, MD	SVP, Medical Services
CCA CMO or Designee [Print]	**Title [Print]**
	3/4/2021
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