



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Gender Affirming Surgery and Related Procedures		
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Clinical: <input checked="" type="checkbox"/>	Operational: <input checked="" type="checkbox"/>	Informational: <input type="checkbox"/>
Benefit Type: <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid	Approval Date: 3/4/2021;	Effective Date: 05/22/2021;
Last Revised Date: 09/09/2021; 10/14/2021; 6/2/2022; 3/9/2023	Next Annual Review Date: 3/4/2022; 09/09/2022; 10/14/2022; 6/2/2023; 3/9/2024	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.



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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 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



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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.
- 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 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 six months.
 - b. Both independently qualified licensed health professional noted in subsection B.2.a. above,



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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.
- 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



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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.
- 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



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 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, 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



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

KEY CARE PLANNING CONSIDERATIONS:

N/A

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
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
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
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19316	Mastopexy
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)
21137	Reduction forehead; contouring only



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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
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
54660	Insertion of testicular prosthesis (separate procedure)
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

Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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)
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)
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



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

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)

REGULATORY NOTES:

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 considering the individual member's health care needs. If at any time a CMS Local or National Coverage Determination (LCD or NCD) is published that is more expansive than the criteria set forth herein, the NCD or LCD criteria shall supersede these criteria.

This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

1. MassHealth Guidelines for Medical Necessity Determination for Gender-Affirming Surgery (MNG-GAS 09/21)
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.
4. Centers for Medicare & Medicaid Services National Coverage Determination (NCD) 140.9. Gender Dysphoria and Gender Reassignment Surgery. Date 8/30/2016.

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.

Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

3. Hembree WC, Cohen-Kettenis HA, Delmarre-van de Waal, et al. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2009;94:3132-54.
4. Wierckx K1, Gooren L, T'sjoen G. Clinical Review: Breast Development in Trans Women Receiving Cross-Sex Hormones. *J Sex Med.* 2014 Mar 12. doi: 10.1111/jsm.12487. [Epub ahead of print]
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7. Wagner S, Greco F, Hoda MR, et al. Male-to-Female Transsexualism: Technique, Results and 3-Year Follow-up in 50 Patients. *Urol Int.* 2010;84(3):330-3.
8. Byne W, Bradley S, Coleman E, et al. Report of the APA Task Force on Treatment of Gender Identity Disorder. *Am J Psychiatry.* 2012; Suppl.:1-35.
9. Seal LJ, Granklin S, Richards C, et al. Predictive Markers for Mammoplasty and a Comparison of Side Effect Profiles in Transwomen Taking Various Hormonal Regimens. *J Clin Endocrinol Metab.* 2012;97(12):4422-8.
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.
11. Morrison S, Vyas K, Motakef S, et al. Facial feminization: systematic review of literature. *Plastic and reconstructive Surgery.* 2016; 136 (6): 1759-1770.
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 Feminization 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.
15. Rhode Island Executive Office of Health and Human Services. Prior Approval (PA) Criteria for Surgical Procedures. Gender Dysphoria/Gender Nonconformity Coverage Guidelines. <https://eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/Physician/PriorApprovalCriteriaforSurgicalProcedures.aspx>.
16. MassHealth Guidelines for Medical Necessity Determination for Gender-Affirming Surgery. MNG-GAS-0921. 9/1/2021. <https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-gender-affirming-surgery>.
17. MassHealth Guidelines for Medical Necessity Determination for Hair Removal. MNG-HR-0921. 9/1/2021. <https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-hair-removal>.
18. Centers for Medicare & Medicaid Services National Coverage Determination (NCD) 140.9. Gender Dysphoria and Gender Reassignment Surgery. Date 8/30/2016. <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=368&ncdver=1&keywordtype=starts&keyword=gender&bc=0>.



Gender Affirming Surgery and Related Procedures Medical Necessity Guideline

ATTACHMENTS:

EXHIBIT A	
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REVISION LOG:

REVISION DATE	DESCRIPTION
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:

Peggy Johnson, MD

CCA Senior Clinical Lead [Print]

Signature

Vice President & Chief of Psychiatry

Title [Print]

3/4/2021

Date

David Mello

CCA Senior Operational Lead [Print]

Senior Medical Director Utilization Review and
Medical Policy

Title [Print]

12/31/23

Nazlim Hagmann

CCA CMO or Designee [Print]

Signature

Chief Medical Officer

Title [Print]

12/31/23

Date