

# Medical Policy

**cPolicy:** 201609

**Initial Effective Date:** 08/01/2016

**SUBJECT:** Gender Affirming Surgery

**Annual Review Date:** 01/11/2022

**Last Revised Date:** 02/11/2022

**Prior approval is required for some or all procedure codes listed in this Corporate Medical Policy.**

**Definition:** Gender dysphoria<sup>†</sup> is the discomfort or distress that is caused by a discrepancy between an individual's gender identity and that individual's sex assigned at birth. Medical treatment includes feminization (male-to-female or MtF) or masculinization (female-to-male or FtM) of the body through hormone therapy and/or surgery, and psychotherapy including counseling and support. Gender affirming surgery refers to surgical procedures for the treatment of gender dysphoria. Surgery may include several staged procedures.

**Medical Necessity:** The Company considers gender affirming surgery **medically necessary** and eligible for reimbursement providing that the following criteria are met:

For breast surgery:

- A written assessment from at least one qualified behavioral health professional that documents that the individual meets **all** of the following:
  - ≥ 18 years old; and
  - Capacity to make a fully informed decision and to consent for treatment that may be irreversible; and
  - Persistent, well-documented diagnosis of gender dysphoria<sup>†</sup>; and
  - Absence of poorly controlled or unstable psychiatric condition.

**NOTE:** The written assessment **MUST** include a letter of referral that conforms to the requirements set forth by the World Professional Association for Transgender Health (WPATH) Standards of Care<sup>††</sup>.

For genital surgery:

- A written assessment from at least two qualified behavioral health professionals that documents that the individual meets **all** of the following:
  - ≥ 18 years old; and
  - Capacity to make a fully informed decision and to consent for treatment that may be irreversible; and
  - Persistent, well-documented diagnosis of gender dysphoria<sup>†</sup>
  - Absence of poorly controlled or unstable psychiatric condition; and

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- Completed hormone therapy of at least 12 continuous months for feminization or masculinization unless medically contraindicated; and
- Documented history of preoperative, 12 continuous months of living in a gender role that is congruent with gender identity.

**NOTE:** The written assessment **MUST** include letters of referral that conform to the requirements set forth by the WPATH Standards of Care<sup>††</sup>.

**Medically necessary** surgical procedures may include the following:

- Male-to-female (MtF): breast augmentation, clitoroplasty, coloproctostomy, labiaplasty, orchiectomy, penectomy, vaginoplasty, urethroplasty, vulvoplasty.
- Female-to-male (FtM): bilateral mastectomy or breast reduction, hysterectomy, implantation of penile and/or testicular prostheses, metoidioplasty, nipple-areola reconstruction following gender-affirming mastectomy\*, salpingo-oophorectomy, urethroplasty, phalloplasty, scrotoplasty, vaginectomy, vulvectomy.

**\*NOTE:** CPT code 19318 (breast reduction) includes the work necessary to reposition and reshape the nipple and areola. CPT code 19350 (nipple/areola reconstruction) is considered integral to CPT code 19318; thus CPT codes 19350 and 19318 should not be billed together for mastectomy for the purpose of gender affirming surgery. However, when appropriate, CPT code 19350 may be requested along with CPT code 19303 (mastectomy, simple, complete).

The Company considers certain procedures **cosmetic** and **not** eligible for reimbursement when performed as part of gender affirming surgery, including, but not limited to, the following:

- |   |   |
|---|---|
| • Abdominoplasty  | • Laryngoplasty   |
| • Blepharoplasty  | • Lipofilling/collagen injections                       |
| • Botulinum toxin   | • Liposuction or lipoplasty                             |
| • Brow lift   | • Lip reduction/enhancement                             |
| • Calf implants   | • Neck tightening                                       |
| • Collagen injections   | • Pectoral implants                                     |
| • Dermal filler injections  | • Removal of redundant skin                             |
| • Facial implants   | • Rhinoplasty   |
| • Facial modifications including facial feminization and face lift        | • Skin resurfacing                                      |
| • Gluteal augmentation including implants/lipofilling                     | • Thyroid chondroplasty (reduction of the Adam's apple) |
| • Hair reconstruction including permanent hair removal or hair transplant | • Other aesthetic or cosmetic procedures not listed     |

The Company considers certain procedures as **not medically necessary** and **not** eligible for reimbursement when performed as part of gender affirming surgery, including, but not limited to, the following:

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- Reproduction services (cryopreservation, storage and thawing of reproductive tissue)
- Speech therapy for vocal training
- Vocal cord procedures (voice modification surgery)

## NOTES:

- Reversal of gender affirming surgery is not eligible for reimbursement.
- Hormone therapy is subject to the individual's prescription drug benefit plan.
- Current certificate books exclude coverage for surgical and non-surgical management of gender dysphoria.
- To verify coverage refer to member mailings and updated certificate books as they become available.

## †Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Criteria for Gender Dysphoria (APA, 2013):

### Gender dysphoria in Adolescents and Adults

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
  4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**With a disorder of sex development** (e.g., a congenital adrenogenital disorder such as 2.55.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen insensitivity syndrome).

**Coding note:** Code the disorder of sex development as well as gender dysphoria.

*Specify if:*

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**Post transition:** The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender affirming surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female).

**††Written documentation includes a letter of referral conforming to the World Professional Association for Transgender Health (WPATH) Standards of Care and should cover six key elements (WPATH, 2011):**

1. The patient's general identifying characteristics.
2. Results of the patient's psychosocial assessment including any diagnoses.
3. Duration of the mental health professional's relationship with the patient including the type and duration of counseling or therapy to date.
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale supporting the patient's request for surgery.
5. A statement confirming that informed consent has been obtained from the patient.
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this relationship.

*Medical Mutual of Ohio complies with the Mental Health Parity and Addiction Equality Act (MHPAE). This Corporate Medical Policy applies to covered plans (individual and group) which are subject to the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) and to groups who may be exempt from the requirements of MHPAEA but still elect to provide coverage.*

## **Documentation Requirements:**

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

**NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.**

*Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.*

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*Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.*

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## Sources of Information:

- American College of Obstetricians and Gynecologists (ACOG). (2021, March). Health Care for Transgender and Gender Diverse Individuals (Number 823). Retrieved from <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>. Accessed January 11, 2022.
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.
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- UpToDate, Waltham, MA:
  - Ferrando C, Zhao LC, Nikolavsky D. (2022). Gender-affirming surgery: Female to male. Brubaker L (Ed).
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  - Olson-Kennedy J, Forcier M. (2020). Management of transgender and gender-diverse children and adolescents. Bren D, Geffner ME, Blake D (Eds).
- van de Grift TC, Kreukels BPC, Elfering L, Özer M, Bouman M-B, Buncamper ME, ... Mullender MG. (2016). Body Image in Transmen: Multidimensional Measurement and the Effects of Mastectomy. *J Sex Med*, 13(11):1778–1786.
- World Professional Association for Transgender Health (WPATH). (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Version 7. Minneapolis, MN: World Professional Association for Transgender Health (WPATH). Available at: [https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7\\_English2012.pdf?t=1613669341\\_English.pdf](https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?t=1613669341_English.pdf). Accessed January 11 2022.

Applicable Code(s):	
<b>CPT:</b>	17999, 19303, 19318, 19325, 19340, 19342, 19350, 44145, 53430, 54125, 54400, 54401, 54405, 54520, 54660, 54690, 55180, 55970, 55980, 56625, 56800, 56805, 57110, 57291, 57292, 57335, 58150, 58262, 58291, 58552, 58554, 58571, 58573, 58661
<b>HCPCS:</b>	L8699
<b>ICD-10-CM Procedure Codes</b>	0UQG0ZZ, 0UQJ0ZZ-0UQJXZZ, 0UT20ZZ-0UT2FZZ, 0UT70ZZ-0UT7FZ, 0UT90ZZ-0UT9FZZ, 0UTC0ZZ-0UTC8ZZ, 0UTG0ZZ-0UTG8ZZ, 0UTJ0ZZ-0UTJXZZ, 0UTM0ZZ-0UTMXZZ, 0VRC0JZ, 0VTC0ZZ-0VTC4ZZ, 0VTS0ZZ-0VTSXZZ, 0VUS07Z-0VUSX7Z, 0VUS0JZ-0VUSXJZ, 0VUS0KZ-0VUSXKZ, 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0, 0W4N071, 0W4N0J1, 0W4N0K1, 0W4N0Z1
<b>ICD10 Diagnosis Codes:</b>	F64.0, F64.1, F64.2, F64.8, F64.9

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