Clinical Policy: Gender Affirming Surgery for the Treatment of Gender Dysphoria in Adults

Reference Number: IL.CP.MP.558
Last Review Date: 11/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

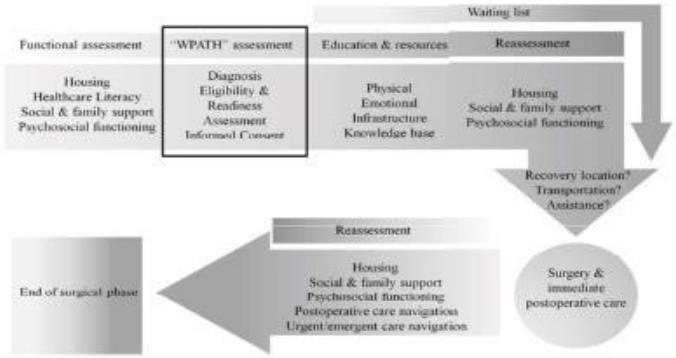
Definitions:

Gender Dysphoria	A condition in which there is marked incongruence between an individual's experienced/expressed gender and assigned gender, which is associated with clinically significant distress or impairment in social, school, or other important areas of functioning. (DSM-V). Individuals with gender dysphoria have persistent feelings of gender discomfort with their anatomical sex, strong and ongoing cross-gender identification, and the desire to live and be accepted as a member of the opposite sex. Hayes)
Gender Affirming Surgery	Surgical procedures that change one's body to conform to one's gender identity. These procedures may include "top surgery" (breast augmentation or removal) and "bottom surgery" (altering the genitals.)
Licensed Practitioner of the Healing Arts	As defined in 89 Ill Adm. Code 140.453, A LPHA is one of the following: Physician, Licensed APRN with psychiatric specialty, Licensed Clinical Psychologist, Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist. Or Licensed Clinical Social Worker.
Qualified Mental Health Professional	"Qualified Mental Health Professional" or "QMHP" means one of the following: Any individual identified as an LPHA. A registered professional nurse who holds a valid license in the state of practice, is legally authorized under state law or rule to practice as registered nurse or registered professional nurse, so long as that practice is not in conflict with the Illinois Nurse Practice Act, and has training in mental health services or one year of clinical experience, under supervision, in treating problems related to mental illness, or specialized training in the treatment of children and adolescents. An occupational therapist who holds a valid license in the state of practice and is Authorized under state law or rule to practice as an occupational therapist, so long as that practice is not in conflict with the Illinois Occupational Therapy Practice Act, with at least one year of clinical experience in a mental health setting. If the state of practice does not provide a legal authority for licensure, the individual must meet the requirements of 42 CFR 484.4 for an occupational therapist. An individual who possesses a master's or doctoral degree in counseling and guidance, rehabilitation counseling, social work, psychology, pastoral counseling, family therapy, or a related field and has: Successfully completed 1,000 hours of practicum and/or internship under clinical and educational supervision; or One year of documented clinical experience under the supervision of a QMHP.
WPATH	World Professional Association for Transgender Health.

Clinical Background:
Gender Dysphoria is condition in which there is marked incongruence between an individual's experienced/expressed gender and assigned gender (DSM-V). When gender and natal sex do not match, or gender and perceived sex do not match, emotional pain and confusion can result. When the resulting distress creates functional impairment, gender dysphoria may be diagnosed. Treatment options may include, psychotherapy, social transition, hormone therapy and surgery or associated procedures for gender reassignment or affirmation, which can involve surgical procedures including genital reconstruction surgery, breast/chest surgery, and other procedures as considered medically necessary.

Gender dysphoria does not fit traditional concepts of medical necessity since research to date has not established anatomical or physiological anomalies associated with Gender Dysphoria. There is some evidence in adults that suggests positive benefits, such as: decreased Gender Dysphoria, decreased depression and anxiety and increased quality of life. However, due to serious limitations in the quality of research evidence to date, no conclusions can yet be made regarding the comparative benefits of hormone therapy along with GRS, or about different components of GRS. (Hayes, 2021) Gender Affirmation or Reassignment surgery refers to any procedure designed to allow a person to resemble the opposite gender and to facilitate sexual function. Patients may not elect to undergo all possible procedures, and some procedures, such as hysterectomy/oophorectomy in FtM patients, may be viewed as necessary, such as, for safe long-term administration of androgens.

Preoperative assessment for Gender Affirmation or Reassignment surgery has historically focused on diagnosis, informed consent and specific criteria assessment. However, recovery from gender-affirming or reassignment surgeries can be complex and involved processes. Preoperative assessment needs to include not only the WPATH assessment, but evaluation of psychosocial functioning, housing status, social support system, transportation, health literacy and access to emergency care during the postoperative period. (Wang et al, Guidelines PGACT, p.122, p.124.) Postoperative care supports are especially important in promoting successful surgical outcomes for under resourced or medically indigent patients.



Adapted from: Deutsch MB. Gender-affirming Surgeries in the Era of Insurance Coverage: Developing a Framework for Psychosocial Support and Care Navigation in the Perioperative Period. J Health Care Poor Underserved; May 2016.

Policy: Gender-affirming surgeries shall be determined to be medically necessary when provided to individuals 1) over the age of 21; 2) with a diagnosis of Gender Dysphoria; 3) when supported by sufficient medical documentation, and 4) upon submission of one or more letters from a qualified practitioner. Exceptions to the age provisions may be considered on a case-by-case basis when medical necessity is demonstrated and prior approval has been received.

Genital surgery must be performed by an urologist, gynecologist, or plastic or general surgeon who is board certified in the practitioner's area of expertise and has demonstrated specialized competence in gender-based genital reconstruction as indicated by documented supervised training or post-graduate training in the field of gender-based reconstruction.

Gender Affirming Services That May Be considered Medically Necessary:

Procedure:
Criteria for Coverage:
Table 1: DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents:

a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following:
   i. 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)
   ii. 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)
   iii. A strong desire for the primary and/or secondary sex characteristics of the other gender
   iv. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
   v. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
   vi. 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.

General Information Required:
Gender Reassignment surgery must be prior authorized by Meridian Health Plan. The following documentation (including format and content detailed referenced in the Appendices), must be submitted for review to substantiate that all of the following applicable authorization criteria or requirements have been met:

1. Requirements for non-genital gender-affirming surgery:
   a. One letter from either the participant's primary care physician or the physician managing the individual's gender-related healthcare who has assessed the individual and is referring the individual for gender-affirming services,**); and
   b. Persistent, well-documented gender dysphoria (see Table 1 DSM 5 criteria below); and
   c. Capacity to make a fully informed decision and to consent for treatment; and
   d. Age of majority (Age 21 or older unless there is a case-based exception); and
   e. If significant medical or mental health concerns are present, they must be reasonably well controlled with documentation as such from the treating physician; and
   f. Documentation of twelve months of living in a gender role that is congruent with their gender identity (real life experience) across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings). The medical documentation should include the start date of living full time in the new gender. Verification with documentation from individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, and regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner

*Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.
** The contents of the practitioner letter(s) must adhere to the requirements found in 89 Ill. Adm. Code 140.413(a)(16)

2. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):
   a. One letter from either the participant's primary care physician or the physician managing the individuals gender-related healthcare who has assess the individual and is referring the individual for gender affirming services, including surgery, a second letter from a Licensed Practitioner of the Healing Arts (LPHA) as defined in 89 Ill. Adm. Code Section 140.453(b)(3)(A-D,F) who has assessed the individual and is referring the individual for gender-affirming services, including surgery*; and
   b. Persistent, well-documented gender dysphoria (see Table 1 DSM 5 criteria below); and
   c. Capacity to make a fully informed decision and to consent for treatment; and
   d. Age of majority (Age 21 or older unless there is a case-based exception); and
   e. If significant medical or mental health concerns are present, they must be reasonably well controlled with documentation as such from the treating physician; and
   f. Documentation of twelve months of continuous hormone therapy immediately preceding the request for gender reassignment surgery (unless the member has a medical contraindication as documented by treating physician in clinical or office notes)
   g. Documentation of twelve months of living in a gender role that is congruent with their gender identity (real life experience) across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings). The medical documentation should include the start date of living full time in the new gender. Verification via documentation from individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, and regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner.
   h. * The contents of the practitioner letter(s) must adhere to the requirements found in 89 Ill. Adm. Code 140.413(a)(16)
3. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female): The use of hair removal procedures to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure is considered medically necessary when performed by a licensed dermatologist and when the aforementioned procedures (phalloplasty or vaginoplasty) have been prior authorized/approved.
   a. One letter from either the participant's primary care physician or the physician managing the individuals gender-related healthcare who has assess the individual and is referring the individual for gender-affirming services, including surgery, a second letter from a Licensed Practitioner of the Healing Arts (LPHA) as defined in 89 Ill. Adm. Code Section 140.453(b)(3)(A-D,F) who has assessed the individual and is referring the individual for gender-affirming services, including surgery*; and
   b. Persistent, well-documented gender dysphoria (DSM5 criteria below); and
   c. Capacity to make a fully informed decision and to consent for treatment; and
   d. Age of majority (Age 21 or older unless there is a case-based exception); and
   e. If significant medical or mental health concerns are present, they must be reasonably well controlled with documentation as such from the treating physician; and
   f. Twelve months of continuous hormone therapy immediately preceding the request for gender reassignment surgery (unless the member has a medical contraindication as documented by treating physician in clinical or office notes); and
   g. Documentation of twelve months of living in a gender role that is congruent with their gender identity (real life experience) across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings). The medical documentation should include the start date of living full time in the new gender. Verification via documentation from individuals who have

related to the individual in an identity congruent gender role, or requesting documentation of a legal name change, and regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner.

*The contents of the practitioner letter(s) must adhere to the requirements found in 89 Ill. Adm. Code 140.413(a)(16)

Gender Reassignment Surgeries and Related Services

1. Secondary Sexual Characteristic (Masculinizing or Feminizing) Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered medically necessary for the treatment of gender dysphoria ONLY. These procedures may include the following:

- Abdominoplasty
- Blepharoplasty
- Brow lift
- Calf implants
- Cheek implants
- Chin or nose implants
- External penile prosthesis (vacuum erection devices)
- Face Lift
- Facial bone reconstruction/sculpturing/reduction, including jaw shortening
- Forehead lift or contouring
- Hair removal (laser hair removal or electrolysis) which may include donor skin sites, or hair transplantation (hairplasty)
- Laryngoplasty
- Lip reduction or lip enhancement
- Liposuction/lipofilling, body contouring or modeling of waist, buttocks, hips, and thigh reduction
- Neck tightening
- Pectoral implants
- Reduction thyroid chondroplasty or trachea shaving
- Redundant/excessive skin removal
- Rhinoplasty
- Skin resurfacing
- Testicular expanders
- Voice modification surgery, and/or
- Voice lessons

2. Surgical repairs or revisions related to MtF or FtM procedures may be required, such as removal and replacement of prostheses.
3. Gender Primary or Secondary Sexual Characteristic Revisions Surgeries

When there is documented evidence of physical functional impairment, gender primary or secondary sexual characteristic revision procedures are considered medically necessary.

When there is no documented evidence of physical functional impairment, gender primary or secondary sexual characteristics revision services are considered not medically necessary: refer to the appropriate procedure-specific policy.

4. Reversal of Gender Reassignment Surgical Procedures

For reversal of any of the prior gender reassignment surgical procedures or services for gender primary or secondary sexual characteristics, the patient must meet the same criteria for gender dysphoria to have those reversal procedures considered medically necessary.

If the criteria for gender dysphoria is not met, then reversal of any prior gender reassignment surgical procedures or services for gender primary or secondary sexual characteristics is considered not medically necessary.

CPT®* Codes	Description

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		12/20
Annual Review	12/22	12/22
Annual Review	11/23	01/24

All: The Chief Medical Officer and/or Senior Medical Director must receive notification for all possible approved requests by the UM team.

IL: Refer to 89 Ill. Adm. Code 140 for adopted rules. Per 2020 Illinois Register Vol.44 Issue 1, page 226 :Amendments to 89 Ill. Adm. Code 140, Sections 140.412, 140.413, 140.440. Effective on or after 1/1/2020. Payment for gender-affirming surgeries, services and procedures for patients under 21 years of age will be made in specific cases if medical necessity is demonstrated and prior approval is received. https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200109a.aspx Payment for gender-affirming surgeries, services and procedures for patients under 21 years of age will be made in specific cases if medical necessity is demonstrated and prior approval is received. https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200109a.aspx

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State Letters/Bulletins					
CMS National/Local Coverage Determination (NCD/LCD)					
Medicare Managed Care Manual:					
Medicaid CFR:					
State Administrative Codes:					
Contract Requirements:					
Related Policies:					
Related Desk Level Procedures/ Job Aids/Template Letters:					
Related Algorithms/Flowcharts/ Attachments					

Appendix A

Table 2: Format and content for referral letters from Qualified Mental Health Professional (including Licensed Practitioner of the Healing Arts):

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

Note: There is no minimum duration of relationship required with mental health professional. It is the professional's judgment as to the appropriate length of time before a referral letter can appropriately be written. A common period of time is three months, but there is significant variation in both directions. When two letters

are required, the second referral is intended to be an evaluative consultation, not a representation of an ongoing long-term therapeutic relationship.

Appendix B

Table 3: Characteristics of a Qualified Mental Health Professional: As established by the World Professional Association for Transgender Health (WPATH), minimum credentials for a mental health professional to be qualified to evaluate or treat individuals considering gender reassignment surgery include ALL the following:

1. Master's degree or equivalent in a clinical behavioral science field, or a more advanced degree, granted by an institution accredited by the appropriate national or regional accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent; and
2. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; and
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; and
4. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and
5. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions, or exclusions, conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions, exclusions take precedence. Please refer to the state Medicaid manual for any coverage provisions, or exclusions pertaining to this clinical policy.