MetroPlus Health

Policy and Procedure

Title: Gender Reassignment Surgery	Division: Medical Management Department: Utilization Management
Approval Date: 8/9/17	LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, GoldCare I&II, Market Plus, Essential, HARP, UltraCare
Effective Date: 8/9/17	Policy Number: UM-MP208
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POLICY DESCRIPTION:
Gender Reassignment Surgery

1. RESPONSIBLE PARTIES:
Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claims Department, Provider Contracting.

2. DEFINITIONS:

Gender identity	The sense of being male or female that is usually in accord with, but sometimes opposed to, physical anatomy.
Gender dysphoria	Refers to discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) 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 sex. Only some gender nonconforming people experience gender dysphoria at some point in their lives.
Transgender	Refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their gender at birth.
Transsexual	Refers to an individual who seeks, or has undergone, a social transition from male to female or female to male. In many, but not all, cases this also involves a physical transition through cross-sex hormone treatment and genital surgery (sex reassignment surgery).
Hormonal gender reassignment	The administration of androgens to genotypic and phenotypic females and estrogen or progesterone to genotypic or phenotypic males for the purpose of effecting somatic changes to more closely approximate the physical appearance of the genotypically other sex. Hormones are also utilized for pubertal suppression. Hormonal gender reassignment does not refer to the administration of hormones for the purpose of medical care or research conducted for the treatment or study of non-gender-dysphoric medical conditions (i.e., aplastic anemia, impotence, cancer).
Genital surgical gender reassignment	Genital surgery that alters the morphology to approximate the physical appearance of the genetically other sex. The surgical procedures on the table in Section 6 below occurring in the absence of any diagnosable

	birth defect or other medically defined pathology (except gender dysphoria) are included in this category.

3. POLICY:

A. Hormone therapy (whether or not in preparation for gender reassignment surgery) will be covered for members ≥ 16 years of age as follows:

1. Treatment with gonadotropin-releasing hormone agents (pubertal suppressants) when based upon a determination by a qualified medical professional that the member is eligible and ready for such treatment, i.e., that the member:
    a. Meets gender dysphoria diagnostic criteria;
    b. Has experienced puberty to at least Tanner stage 2 with pubertal changes resulting in increased gender dysphoria;
    c. Does not suffer from psychiatric comorbidity that interferes with diagnostic work-up or treatment;
    d. Has adequate psychological and social support during treatment;
    e. Demonstrates knowledge and understanding of expected treatment-outcomes associated with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment.
2. Treatment with cross-sex hormones for members ≥ 16 years of age when based upon a determination of medical necessity made by a qualified medical professional. (Members < 18 years of age must meet Criteria # 1).

Note: Requests for coverage of cross-sex hormones for members <16 years of age who meet Criteria #1, will be reviewed on a case-by-case basis.

B. Gender reassignment surgery will be covered for members ≥ 18 years of age.

1. The request must be accompanied by letters from two qualified New York State (NYS) licensed health professionals, acting within the scope of his/her practice, who have independently assessed the member and are referring the member for the surgery. While the two qualified New York State licensed health professionals must assess independently, they do not have to be practicing at different organizations.
    a. One letter must be from a psychiatrist, psychologist, psychiatric nurse practitioner (NP) or licensed clinical social worker (CSW) with whom the member has an established and ongoing relationship.

b. The other letter may be from a psychiatrist, psychologist, physician, psychiatric NP or licensed CSW who has only an evaluative role with the member.

2. Together, the letters must establish that the member:
    a. Has a persistent and well-documented case of gender dysphoria;
    b. Has received hormone therapy (not prerequisite for mastectomy) appropriate to member's gender goals for a minimum of 12 months prior to seeking genital surgery (unless medically contraindicated or the member is otherwise unable to take hormones);
    c. Has lived 12 months in gender role congruent with member's gender identity and has received mental health counseling as deemed medically necessary during that time;
    d. The duration and frequency of mental health counseling is dependent on the enrollee's unique clinical profile and biopsychosocial circumstances.
    e. Has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so, that those are reasonably well-controlled prior to the gender reassignment surgery;
    f. Has the capacity to make fully informed decisions and consent to treatment.

C. The following gender reassignment surgeries, services, and procedures are available, based on a determination of medical necessity by a qualified medical professional (this pertains to the initial surgery, for revisions see section D below):
    1. mastectomy, hysterectomy, salpingectomy, oophorectomy, vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, penectomy, orchiectomy, vaginoplasty, labiaplasty, clitoroplasty, and/or placement of a testicular prosthesis and penile prosthesis;
    2. breast augmentation, provided that: the individual has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the patient is otherwise unable to take hormones; and
    3. electrolysis when required for vaginoplasty or phalloplasty.
    4. The above services (1,2,3) are subject to administrative prior authorization requirements; however, the plan must accept the qualified medical professional's determination of medical necessity.

5. Any other surgeries, services, and procedures in connection with gender reassignment not listed above, including those done to change the patient's physical appearance to more closely conform secondary sex characteristics to those of the patient's identified gender, will be covered if it is demonstrated that such surgery, service, or procedure is medically necessary to treat a particular patient's gender dysphoria, and prior approval is received. Examples include thyroid cartilage reduction, pectoral implants, gluteal augmentation, hair reconstruction, voice surgery and facial feminization surgery.
6. Coverage is not available for surgeries, services, or procedures that are purely cosmetic, i.e., that enhance a patient's appearance but are not medically necessary to treat the patient's underlying gender dysphoria. Examples of such surgeries include rhinoplasty, eye/lid lifts, ear pinning (otoplasty) and brow lifts (see Section 5D, below).
7. Although the minimum age for Medicaid coverage of gender reassignment surgery is generally 18 years of age, the revised regulations allow for coverage for individuals under 18 in specific cases if medical necessity is demonstrated and prior approval is received.

D. Surgical revision requests for the medically necessary procedures listed above cannot be subjected to medical necessity review.

4. LIMITATIONS/ EXCLUSIONS:

A. Requests for gender reassignment surgery, services and procedures for members < 18 years will be reviewed on a case-by-case basis.
B. A case-by-case reviewed will be conducted for members meeting the requirements of surgeries, services and procedures in connection with gender reassignment, if not specified above, or to be performed in situations other than those described above (including those performed to change the physical appearance to more closely conform secondary sex characteristics to those of the member's identified gender).
Clinical documentation must substantiate that such surgery, service or procedure is medically necessary to treat a member's gender dysphoria.
C. The following services and procedures are excluded from coverage:
    1. Cryopreservation, storage, thawing of reproductive tissue (i.e., Ovarian or testicular tissue), and all related services
    2. Reversal of genital and/or breast surgery
    3. Reversal of surgery to revise secondary sex characteristics
    4. Reversal of any procedure resulting in sterilization

D. Breast augmentation will be administratively reviewed for coverage on a case-by-case basis. Consideration will be given to members who have completed ≥ 24 months of hormone therapy; during which time, breast growth has been negligible, or hormone therapy is medically contraindicated, or the member is otherwise unable to take hormones.

E. A medical necessity review will be conducted for any surgeries, services or procedures that are purely cosmetic (i.e., when performed solely to enhance appearance, but not to medically treat the underlying gender dysphoria).
The following surgery, services and procedures will be presumed to be not medically necessary unless justification of medical necessity is provided:

1. Abdominoplasty, blepharoplasty, neck tightening or removal of redundant skin
2. Breast, brow, face or forehead lifts/augmentation, including removal of wrinkles (e.g., rhytidectomy)
3. Calf, cheek, chin, nose or pectoral implants (e.g., genioplasty, mentoplasty, etc.)
4. Collagen injections
5. Drugs to promote hair growth or loss
6. Electrolysis (unless required for vaginoplasty or phalloplasty)
7. Facial bone reconstruction, reduction or sculpturing (including jaw shortening) and Rhinoplasty
8. Hair transplantation
9. Lip reduction
10. Liposuction/lipofilling
11. Osteoplasty
12. Thyroid chondroplasty
13. Voice therapy, voice lessons or voice modification surgery

5. APPLICABLE PROCEDURE CODES:

CPT	Description
19303 Y	Mastectomy, simple, complete
19318	Reduction mammaplasty (unilateral)
19325	Breast augmentation with implant
19304	Mastectomy, subcutaneous
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra.
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra.

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53430	Arthroplasty, reconstruction of female urethra
54120	Amputation of penis: partial
54125	Amputation of penis; complete
54520Y	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522	Orchiectomy, partial
54660	Insertion of testicular prosthesis (separate procedure)
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55150	Resection of scrotum
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55899	Insertion of testicular prosthesis (separate procedure)
55980	Scrotoplasty; complicated
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
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
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

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57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
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)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
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
58292	Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250g; with repair of enterocele
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
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

6. APPLICABLE DIAGNOSIS CODES:

CODE	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.8	Other gender identity disorders (Effective 07/01/2017)
F64.9	Gender identity disorder, unspecified (Effective 07/01/2017)
Z87.890	Personal history of sex reassignment

7. REFERENCES:

i. 18 CRR-NY Title 505.2 (l) Gender dysphoria treatment https://regs.health.ny.gov/volume-c-title-18/content/section-5052-physicians-services

ii. **New York State Medicaid Update - January 2017 Volume 33 – Number 1** https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender

iii. **New York State Medicaid Update - May 2016 Volume 32 - Number 5** https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-05.htm#transgender

iv. **New York State Medicaid Update - June 2015 Volume 31 - Number 6** https://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-06.htm#reg

v. **NYS Physician-Surgery Provider Manual** https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect5.pdf

vi. **Sterilization Consent Form** https://www.health.ny.gov/health_care/medicaid/publications/docs/ldss/ldss-3134.pdf

vii. **New York State Medicaid Update – December 2019 Volumn 35 – Number 12** https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-12.htm

viii. **New York State Department of Financial Services. IVF and Fertility Preservation Law Q&A Guidance. (Part L of Chapter 57 of the Laws of 2019**) https://www.dfs.ny.gov/apps_and_licensing/health_insurers/ivf_fertility_preservation_law_qa_guidance. Accessed November 5th 2020.

8. REVISION LOG:

REVISIONS	DATE
Creation date	8/9/17
Revised	9/14/18
Revised Minor Revision	1/31/20, 4/13/2020
Remove Hormone Therapy requirements and updated limitation/exclusion section	1/20/21
Annual Review with edits	5/31/2022
Annual Review	6/24/2024

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Approved: **Date:**	**Approved:** **Date:**
David Ackman Digitally signed by David Ackman Date: 2024.06.26 11:30:00 -04'00'	Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2024.08.20 10:34:07 -04'00'
David Ackman, MD **VP of Medical Director**	**Sanjiv Shah, MD** **Chief Medical Officer**

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria. Based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication. MetroPlus Health Plan has adopted the here in policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.