



Gender Affirming Surgery for ETF Participants

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Policy

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

A. Documentation Required:

1. To facilitate the authorization process, referral requests for gender affirming surgery must include at least one letter or clinical document of readiness for breast/chest surgery and two independent letters of readiness for genital surgery from qualified mental health professionals. Qualified mental health professionals must meet the following criteria:
 - i. A Master's degree professional or higher equivalent in a clinical behavioral science or mental health field; **OR**
 - ii. The equivalent in clinical behavioral science granted by an accredited institution.

Note: The letters of readiness for genital surgeries must be from **two independent** evaluations by a qualified mental health professional who meet the training criteria **A.1.i.** above.

2. Referral letters of readiness for **ANY** gender affirming surgery must include the following:
 - i. The patient's general identifying characteristics;
 - ii. Results of the client's psychosocial assessment, including any diagnoses;
 - iii. The duration of the mental health professional's relationship with the patient, including the type of evaluation and therapy or counseling to date;
 - iv. An explanation that the criteria for gender affirming surgery have been met, and a description of the clinical rationale for supporting the patient's request for gender affirming surgery;
 - v. A statement that the patient is making a fully informed decision for surgery;
3. Documentation from the surgical provider that includes the following:
 - i. Surgical history related to previous gender affirming treatment including, facial plastic surgery, breast/chest, and genital surgery; **AND**

- ii. History of previous hormone treatment; **AND**
- iii. Discussion about the nature of the patient's current gender dysphoria and how the requested surgery(ies) will treat this.

B. General Requirements for ALL Gender Affirming Surgical Procedures

Gender affirming surgeries are considered medically necessary for patients who meet

ALL the following criteria:

1. Patient is 18 years of age or older with mental capacity to make an informed decision **OR** for mastectomy only, patient is 16 years of age or older and has documented consent of their parent or legal guardian; **AND**
2. Patient has a diagnosis of persistent, well-documented gender dysphoria; **AND**
3. The patient's co-existing medical and mental health concerns are reasonably controlled; **AND**
4. The surgeon performing the procedures is part of an interdisciplinary team that treats patients with gender dysphoria **OR** has a close association with the mental health and other health professional(s) involved in the treatment of the patient's gender dysphoria; **AND**
5. The surgeon has expertise in performing the gender affirming surgery being requested.

C. Male-to-Female Gender Affirming Surgical Procedures

Male to female gender affirming surgeries are considered medically necessary for patients diagnosed with persistent, well-documented gender dysphoria who meet the documentation requirements in **section IA, IB AND** the following procedure specific criteria:

1. **Breast augmentation mammoplasty (using breast implants) with nipple reconstruction.**
At least 12 months of feminizing hormone therapy, (e.g., estrogen and anti-androgen therapy), is required prior to surgery unless the patient has a medical contraindication or is otherwise unwilling or unable to take hormones.
2. **Orchiectomy.** At least 12 months of feminizing hormone therapy, (e.g., estrogen and anti-androgen therapy), is required prior to surgery unless the patient has a medical contraindication or is otherwise unwilling or unable to take hormones.
3. **Genital reconstruction procedures** (e.g., vaginoplasty including laser and electrolysis hair removal of the tissue intended for use in vaginoplasty, labiaplasty, vulvoplasty, clitoroplasty, or penectomy) are considered medically necessary if **ALL** the following criteria are met:
 - i. At least 12 months of feminizing hormone therapy, (e.g., estrogen and anti-androgen therapy), is required prior to surgery unless the patient has a medical contraindication or is otherwise unwilling or unable to take hormones; **AND**
 - ii. 12 continuous months living in a gender role congruent with their gender identity (real life experience); **AND**

- iii. A statement that the mental health professional is available for coordination of care and on-going treatment as needed.

4. Facial feminization procedures

- i. Frontal cranioplasty (forehead contouring);
- ii. Tracheal shave/reduction thyroid chondroplasty;
- iii. Blepharoplasty and brow lift when the criteria in *Medical Policy Ptosis Surgical Procedures* are met;
- iv. Septorhinoplasty when the criteria in *Medical Policy Rhinoplasty-Septorhinoplasty* are met.

NOTES:

1. After initial breast surgery is successfully completed, further modification relating to achieving symmetry is considered not medically necessary.
2. Breast augmentation surgery after healing of initial augmentation is considered cosmetic and considered not medically necessary.
3. If a breast implant was part of a covered initial gender affirming surgery then removal, replacement and/or reconstruction for medical reasons such as implant rupture will be covered.
4. Hair removal typically precedes genital reconstruction surgery by as much as 6-9 months. For hair removal separate from a referral for genital reconstruction surgery, a patient must meet all of the above criteria and have met with the surgeon and found to be a good candidate for surgery with plans for surgery after successful hair removal.

D. Female-to-Male Gender Affirming Surgical Procedures

Female to Male gender affirming surgeries are considered medically necessary for patients diagnosed with persistent, well documented gender dysphoria who meet the documentation requirements in **section IA, IB, AND** the following procedure specific criteria:

1. **Mastectomy with nipple reconstruction** (12 months of hormone therapy **not** required).

2. **Hysterectomy and salpingo-oophorectomy.**

At least 12 months of masculinizing hormone therapy is required prior to surgery unless the patient has a medical contraindication or is otherwise unwilling or unable to take hormones.

3. **Genital reconstruction procedures** (e.g., hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, 2. hair removal on skin intended for phalloplasty with urethral lengthening as an accepted procedure, and implantation of erection and/or testicular prostheses) are considered medically necessary if **ALL** the following criteria are met:

- i. At least 12 months of masculinizing hormone therapy is required prior to surgery unless the patient has a medical contraindication or is otherwise unwilling or unable to take hormones; **AND**

- ii. 12 continuous months living in a gender role congruent with their gender identity (real life experience); **AND**
- iii. A statement that the mental health professional is available for coordination of care and on-going treatment as needed.

NOTES:

- 1. After initial breast surgery is successfully completed, further modification relating to achieving symmetry is considered not medically necessary.
- 2. Hair removal typically precedes genital reconstruction surgery by as much as 6-9 months. For hair removal separate from a referral for genital reconstruction surgery, a patient must meet all of the above criteria and have met with the surgeon and found to be a good candidate for surgery with plans for surgery after successful hair removal.

E. The following reproductive services are not covered as benefit exclusions:

- 1. Cryopreservation of fertilized embryos
- 2. Donor eggs
- 3. Donor sperm
- 4. Gestational carrier
- 5. Oocyte preservation
- 6. Sperm preservation in advance of hormone replacement of gender affirming surgery
- 7. Surrogate parenting/services
- 8. Other assisted reproductive services noted in the ETF certificate of coverage.

Covered Procedures: Male-to-Female

17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue (when specified as permanent hair removal by laser to the tissue intended for use in the vaginoplasty).
19324 -19325	Mammoplasty, augmentation
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
21137	Reduction forehead; contouring only
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
31599	Unlisted procedure, larynx
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
54125	Removal of penis, complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach

54530	Remove Testis, radical
54690	Laparoscopy, surgical; orchiectomy
55180	Revision of scrotum, complicated
55970	Intersex surgery; male to female [a series of staged procedures that includes male genitalia removal, penile dissection, urethral transposition, creation of vagina and labia with stent placement]
56805	Clitoroplasty for intersex state
57291-57292	Construction of artificial vagina
57335	Vaginoplasty for intersex state

Covered Procedures: Female-to-Male

17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue (when specified as permanent hair removal by laser to the tissue intended for use in the vaginoplasty).
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19318	Reduction mammoplasty
19350	Nipple/areola reconstruction
55980	Intersex surgery, female to male [a series of staged procedures that include penis and scrotum formation by graft, and prostheses placement]
56620	Partial simple removal of vulva
57106	Vaginectomy, partial removal of vaginal wall
57110	Vaginectomy, complete removal of vaginal wall
58150, 58180 58260-58262, 58275-58291, 58541-58544, 58550-58554	Hysterectomy
58570-58573	Laparoscopy, surgical with total hysterectomy
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral

References

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