CareSource

# MEDICAL POLICY STATEMENT
# KENTUCKY MARKETPLACE

| Policy Name | | Policy Number | Effective Date |
|---|---|---|---|
| Gender Affirming Surgery | | MM-0746 | 10/01/2021-09/30/2022 |
| **Policy Type** | | | |
| **MEDICAL** | Administrative | Pharmacy | Reimbursement |

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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## A. SUBJECT

**Gender Affirming Surgery**

## B. BACKGROUND

The Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5, 2013) deleted the term "Gender Identity Disorder", and created a new category of "Gender Dysphoria" to reflect its position that gender dysphoria is no longer considered a sexual dysfunction. A clinically significant distress or impairment in social, occupational, or other important area of functioning (in addition to the symptoms noted in DSM-5) is required to diagnose gender dysphoria. Gender nonconformity is not considered to be a psychiatric disorder.

There are typically three approaches that have been attempted to alleviate or to reduce the symptoms of gender dysphoria. These include psychotherapy, hormonal therapy, and gender affirming surgery. Not all individuals with gender dysphoria elect all these approaches. Some individuals with gender dysphoria may wish to use hormones but not elect surgery

## C. DEFINITIONS

- **Female-to-Male (FtM) -** An adjective to describe an individual born or assigned as female at birth ("natal female"), who is changing or who has changed to a more masculine body or gender role.
- **Male-to-Female (MtF) -** An adjective to describe an individual born or assigned as male at birth ("natal male"), who is changing or who has changed to a more feminine body or gender role.
- **Non-Binary/Gender-Queer -** An adjective used to describe an individual who identifies as neither exclusively male or female, but different from gender assigned at birth. Nonbinary individuals may change to a more masculinized or feminized gender role.
- **Gender Dysphoria (GD) -**. The incongruence must be experienced for at least 6 months, and cause distress.
- **Gender Identity -** A category of social identity that refers to an individual's identification as male, female, neither, or a combination of male and female, and may be different from an individual's sex assigned at birth.
- **Behavioral health provider –** Psychologist, psychiatrist or psychiatric nurse practitioner.
- **Sex -** Usually based on the appearance of the external genitalia and defined as male or female as understood in the context of reproductive capacity, such as sex hormones, chromosomes, gonads, and non-ambiguous external and internal genitalia. At times, sex is assigned when external genitalia are ambiguous.
- **Gender affirming surgery -** Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. It has also been referred to as intersex surgery, transgender surgery, gender reassignment, and gender confirmation surgery in the literature. Gender affirming surgery includes "top" surgery, such as mastectomy, and "genital" or "bottom" surgery, such as hysterectomy, oophorectomy, vaginectomy, metoidioplasty, and phalloplasty.

- **Gender affirming surgeon -** Board-certified urologist, gynecologist, or plastic surgeon competent in urological diagnosis and treatment of transgender individuals.

- **Transgender -** An umbrella term for persons whose gender identity, or gender expression does not conform to that typically associated with the sex to which they were assigned at birth. "Trans" is sometimes used as an acceptable shorthand when referring to "transgender."

## D. POLICY

It is the policy of CareSource to comply with state and federal regulations.

CareSource treats all members consistent with their gender identity and does not deny or limit health services that ordinarily or exclusively are available to individuals of one sex to a transgender individual based on the fact that the individual's sex or gender is different from the one to which health services are normally or exclusively available .

CareSource covers those services that are medically necessary. In determining services that are medically necessary, or the coverage of health services related to gender transition, CareSource utilizes neutral standards supported by evidence -based criteria.

**NOTE:** Members under the age of 21 will be reviewed for medical necessity as required by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In general, CareSource considers hormonal treatment for members medically necessary (please refer to pharmacy policy). This is due to the virtual nonexistence of research in these populations, particularly regarding long-term outcomes and safety data and United States IRB oversight. CareSource periodically reviews the literature and reviews policies annually and as needed when new literature comes available. Notwithstanding the foregoing, CareSource does review each request on a case-by-case basis in accordance with medical necessity policies as well as federal and state regulations for sterilization.

I. CareSource considers Gender Affirming surgeries medically necessary when the following clinical criteria are met:
   A. For Breast/chest surgery:
      1. Unless there is a well-documented contraindication or refusal to take hormones, at least twelve months of continuous hormone treatment is required to be considered for surgery.
         a. Hormone trial must be with a medication prescribed to the member.
         b. Hormones must be managed by an experienced physician, physician's assistant, or nurse practitioner working in a center/clinic specializing in the treatment of gender affirming care or endocrinologist
         c. Evidence of lab monitoring of hormone levels must be provided.

      2. A letter of recommendation from a separate behavioral health provider to the surgeon is required. Ideally the letter should come from the treating behavioral health provider If the letter provided is by a master's level practitioner, a second letter should be provided by a psychologist, psychiatrist, or psychiatric nurse practitioner.
         a. The behavioral health provider has evaluated the member within the past twelve months of the time of referral
            01. If member has been in behavioral health treatment, it is preferred that

the recommendation is made by the treating behavioral health provider.

02. If there is not a treating behavioral health provider, a letter of recommendation may be made by a consulting behavioral health provider.
03. If the behavioral health provider is a member of a treatment team with the surgeon, documentation in the integrated clinical record is an option in lieu of a letter.

b. Content of the behavioral health provider referral letter must address all the following:
   01. Duration of evaluator's relationship with the member
   02. Member has well-documented diagnosis of gender dysphoria
   03. A member specific treatment plan to address gender affirming treatment including hormonal treatment and/or surgery, as well as behavioral health during this transition period.
   04. Member has capacity to and did give informed consent for surgery, as well as understanding it may not achieve the desired results
   05. Member is age 18 years or older
   06. Member has had a twelve-month or longer real-life experience congruent with their gender identity. This timeline may be modified with corroborating documentation indicating a safety concern .
   07. The gender dysphoria diagnosis has been consistently persistent for a duration of 6 months or longer at the time of the authorization request.
   08. If co-existing mental illness and/or substance related disorder are present, it is relatively well controlled, there has been no active intravenous drug use for the past 3 months and no suicide attempts or behaviors in the past 6 months.
   09. The behavioral health provider communicates willingness to be available to treat the member during transition or make appropriate referral if member needs assistance with behavioral health treatment.
   10. The degree to which the member has followed the standards of care to date and the likelihood of future compliance

3. Surgeon documentation requirements including all the following:
   a. Assessment including identifying characteristics.
   b. Results of psychological assessment including diagnosis.
   c. Surgery plan.
   d. Documentation of informed consent discussion.
      01. Notation of discussion of risks, benefits alternatives to treatment including no hormonal or surgical treatment.
      02. Notation that member understands that the surgery that may not resolve gender dysphoria.
      03. Medical stability for surgery and anesthesia.
      04. Expected outcome(s).

B. For Genital surgery
   1. At least twelve months of continuous hormone treatment is required to be considered for surgery; unless there is a well-documented contraindication or refusal to take hormones.
      a. A hormone trial must be with a medication prescribed by a provider .

b. Hormones must be managed by an experienced physician, physician's assistant, or nurse practitioner working in a center/clinic specializing in the treatment of gender affirming care, or endocrinologist.
c. Evidence of lab monitoring of hormone levels must be provided.

2. Hair removal may be approved with genital surgery based on medical necessity when skin flap area contains hair needing to be removed.
3. Two letters of recommendation from separate behavior health providers to the surgeon are required. Ideally one of the letters should come from the treating behavioral health specialist. One of the letters provided should be by a psychologist or psychiatrist, or psychiatric nurse practitioner.
   a. The behavioral health provider has evaluated the member within the past twelve months of the time of referral.
      01. If member has been in treatment, it is preferred that one of the recommendations is made by the treating behavioral health provider.
      02. If there is not a treating behavioral health provider, one letter of recommendation needs to be made from a psychologist or psychiatrist, or psychiatric nurse practitioner.
      03. If the behavioral health provider is a member of a treatment team with the surgeon, documentation in the integrated clinical record is an option in lieu of a letter.
   b. Content of referral must address all the following:
      01. Duration of evaluator's relationship with the member.
      02. Member has well-documented diagnosis of gender dysphoria.
      03. Member has capacity to and did give informed consent for surgery.
      04. A member specific treatment plan.
      05. Member is age 18 years or older.
      06. Member has had a twelve-month or longer real-life experience congruent with their gender identity. This timeline may be modified with corroborating documentation indicating a safety concern .
      07. The behavioral health provider communicates willingness to be available to treat the member during transition or make appropriate referral if member needs assistance with behavioral health treatment.
      08. The gender dysphoria diagnosis has been consistently persistent for a duration of 6 months or longer at the time of the authorization request.
      09. If co-existing mental illness and/or substance related disorder are present, it is relatively well controlled, there has been no active intravenous drug use for the past 3 months and no suicide attempts or behaviors in the past 6 months.
      10. The degree to which the member has followed the standards of care to date and the likelihood of future compliance
4. Surgeon documentation requirements include all the following:
   a. Assessment including identifying characteristics.
   b. Results of psychological assessment including diagnosis.
   c. Surgery plan.
   d. Documentation of informed consent discussion.
      01. Notation of discussion of risks, benefits alternatives to treatment including no treatment.
      02. Notation that member understands that the surgery that may not resolve gender dysphoria.
      03. Hair removal.

04. Medical stability for surgery and anesthesia.
05. Expected outcome(s).

e. Evidence that a recommendation was made for the member to consult with an Obstetrician (or other qualified health professional) for conception counseling.

II. The following items are not covered
A. Procedures or surgeries to enhance secondary sex characteristics are considered cosmetic and are not medically necessary.
B. A list of services, procedures or surgeries not covered is included below, this list may not be all inclusive.
1. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
2. Abdominoplasty
3. Blepharoplasty
4. Breast Augmentation
5. Brow Lift
6. Body Contouring
7. Botox Treatments
8. Calf implants
9. Cheek or malar implants
10. Chin Implants
11. Collagen injections
12. Drugs for hair loss or hair growth
13. Face Lifts
14. Facial bone reduction
15. Facial feminization
16. Perineal skin hair removal
17. Hair removal for vaginoplasty without creation of neovagina
18. Hair removal when genital surgery is not yet requested
19. Hair removal when re-assignment surgery is not approved
20. Hair replacement
21. Lip enhancement
22. Lip reduction
23. Liposuction
24. Mastopexy
25. Neck tightening
26. Nose implants
27. Pectoral implants
28. Plastic surgery on eyes
29. Reduction thyroid chondroplasty
30. Rhinoplasty
31. Skin resurfacing
32. Voice modification surgery (laryngoplasty or shortening of the vocal cords)
33. Voice therapy or voice lessons
34. Any other surgeries or procedures deemed not medically necessary
35. Reproduction services including but not limited to sperm preservation, oocyte preservation, cryopreservation of embryos, surrogate parenting, donor eggs and donor sperm and host uterus.

III. CareSource treats all members consistent with the Gender Identity and does not deny or limit health services that ordinarily or exclusively are available to individuals of one sex to a transgender individual based on the fact that the individual's sex or gender is different from the one to which health services are normally or exclusively available. Examples of such services include:
   A. Breast cancer screening for transgender men and nonbinary people who were assigned female at birth
   B. Prostate cancer screening for transgender women and nonbinary people who were assigned male at birth

## E. CONDITIONS OF COVERAGE

NA

## F. RELATED POLICIES/RULES

NA

## G. REVIEW/REVISION HISTORY

| DATES | | ACTION |
|---|---|---|
| Date issued | 05/18/2017 | |
| Date Revised | 05/29/2019 | Updated evidence, changed policy number (was MM-0080), removed pharmacy portions, added additional requirements for consideration of surgery, added specifics on hair removal, items not covered and added types of surgery for medical necessary review |
| | 09/02/2020 | Updated definitions, removed research and put in references, removed codes, updated references, changed letter recommendation requirement, and changed title. |
| | 07/07/2021 | Removed endocrinologist rule, added psychiatric NP, added safety considerations |
| Date Effective | 10/01/2021 | |
| Date Archived | 09/30/2022 | This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy. |

## H. REFERENCES

1. Centers for Medicare & Medicaid (CMS). Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG 00446N). (2016, August 30). Retrieved April 9, 2021 from www.cms.gov
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.
3. World Professional Association for Transgender Health (WPATH). (7th Edition 2001). *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People*. Retrieved April 9, 2021 from www.wpath.org.

4. CMS Department of Health and Human Services Departmental Appeals Board (DAB) has invalidated National Coverage Determination (NCD) 140.3 "Transsexual Surgery" pursuant to section 1869(F)(1)(A)(iii) of the Social Security Act (SSA). (Docket #A-13-47, Decision #2576) dated May 30, 2014. As a consequence of this decision, NCD 140.3 is no longer valid. Implementation of this decision occurred on June 29, 2014
5. Sex Reassignment Surgery for the Treatment of Gender Dysphoria. (2019, August). Retrieved April 9, 2021 from www.hayesinc.com
6. Adelson, S. (2012, September) Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents Adelson, Stewart L. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51(9), 957–974. 10.1016/j.jaac.2012.07.004
7. United States of America Department of Defense. (2020, September 4). Military Service by Transgender Persons and Persons with Gender Dysphoria: An Implementation Handbook. Retrieved April 9, 2021, from www.prhone.defense.gov
8. Zhang, W. R., Garrett, G. L., Arron, S. T., & Garcia, M. M. (2016). Laser hair removal for genital gender affirming surgery. *Translational Andrology and Urology, 5*(3), 381-387. doi:10.21037/tau.2016.03.27
9. Thomas, T. & Ferrando, C. (2021, March). Transgender surgery: Male to female. Retrieved April 9, 2021 from www.uptodate.com
10. Ferrando, C., Zhao, L, & Nikolavsky, D. (2021, March). Transgender surgery: Female to male. Retrieved April 9, 2021 from www.uptodate.com
11. Hembree, W, Cohen-Kettenis, P……T-Sjoen, G. (2017, November). Endocrine Treatment of Gender-Dyshporic/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of clinical Endocrinology & Metabolism*. 102(11), 3869-3903. https://doi.org/10.1210/jc.2017-01658
12. American Psychological Association (2015, December), Guidelines for Psychological Practice With Transgender and Gender Nonconforming People. *American Psychologist.* 70(9), 832-864. http://dx.doi.org/10.1037/a0039906

**The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.**

*Independent medical review – 10/2015*