

MEDICA® UTILIZATION MANAGEMENT POLICY

TITLE: ADULT GENDER REASSIGNMENT SURGERY

EFFECTIVE DATE: December 1, 2015

This policy was developed with input from specialists in psychiatry, urology, plastic surgery, and general surgery, and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member's plan document for specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid and MinnesotaCare members, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica utilization management policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of gender reassignment surgery. The Coverage Issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND

I. Definitions

A. Gender Dysphoria in Adolescents and Adults is a term defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as:

1. 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**:
 - a. 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)
 - b. 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)
 - c. A strong desire for the primary and/or secondary sex characteristics of the other gender
 - d. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
 - e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
 - f. 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).
2. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

B. Genital surgical gender reassignment is surgery of the genitalia performed for the purpose of altering the morphology in order to approximate the physical appearance of the genetically-other gender in persons diagnosed with gender dysphoria. Such surgical procedures as castration, orchiectomy, urethrostomy, penectomy, vaginoplasty, labiaplasty, hysterectomy, salpingectomy, vaginectomy, oophorectomy, and

phalloplasty, that occur in the absence of any diagnosable birth defect or other medically defined pathology other than gender dysphoria, are included in this category. Genital electrolysis is not considered a surgical procedure, but is performed in conjunction with genital surgery.

- C. **Hormonal gender reassignment** is the administration of androgens to genotypic and phenotypic females, and the administration of estrogen and/or progesterones to genotypic and phenotypic males, for the purpose of effecting somatic changes in order for the patient to more closely approximate the physical appearance of the genotypically-other gender in persons diagnosed with gender dysphoria. Hormonal gender reassignment does not refer to the administration of hormones for the purpose of medical care and/or research conducted for the treatment or study of non-gender dysphoric medical conditions (e.g., aplastic anemia, impotence, cancer).
- D. **Non-genital surgical gender reassignment** is any and all other surgical procedures of non-genital sites (breasts, skin, nose, throat, chin, cheeks, hips, waist, etc.) conducted for the purpose of effecting a more masculine appearance in a genetic female or a more feminine appearance in a genetic male.
- E. The **Transgender Real-Life Experience** is undertaken to assess the ability and resolve of persons undergoing gender reassignment to fully adapt to and successfully function in their new or evolving gender role or presentation. The transgender real-life experience allows persons with gender dysphoria and their clinicians to determine whether or how to proceed with further treatment.

II. Comments

- A. Treatment of gender dysphoria consists of three elements: a real-life experience in the other gender role, receiving hormones of the other gender, and surgery. Once the diagnosis of gender dysphoria is made, a variety of options should be considered. However, not all persons with gender dysphoria need or want all three elements of therapy. Some persons with gender dysphoria require only psychotherapy to adapt to a more comfortable gender identity. Others may require hormonal treatments in conjunction with psychotherapy.
- B. Members considering surgery must demonstrate knowledge of the length and associated cost of treatment, required lengths of hospitalizations, likely complications, and post-surgical rehabilitation requirements of various surgical approaches.
- C. Information on different competent surgeons must be provided to members prior to undergoing surgery.

MEDICAL NECESSITY CRITERIA

I. Indications

Adult gender reassignment surgery is medical necessary when **all of the following** criteria are met (adapted from the World Professional Association for Transgender Health Inc., Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, (Seventh Version 2011)):

- A. The member must have a diagnosis of gender dysphoria from the Diagnostic and Statistical Manual of Mental Disorders [DSM 5-TR, 2013] section 302.6 (F64.1)).
- B. Eligibility criteria for specific surgeries:
 - 1. Criteria for mastectomy for female to male
 - a. The member has persistent, well-documented gender dysphoria
 - b. The member is 18 years of age or older
 - c. The member has the capacity to make a fully informed decision and to consent for treatment
 - d. If significant medical or mental health concerns are present, documentation must support that they are reasonably well-controlled.
 - * NOTE: Hormonal treatment is **not** a prerequisite for mastectomy.
 - 2. Criteria for breast augmentation for male to female
 - a. The member has persistent, well-documented gender dysphoria
 - b. The member is 18 years of age or older
 - c. The member has the capacity to make a fully informed decision and to consent for treatment
 - d. If significant medical or mental health concerns are present, documentation must support that they are reasonably well-controlled.
 - e. Twelve months of continuous hormonal gender reassignment treatment must be completed.
 - 3. Criteria for genital surgery
 - a. The member is 18 years of age or older
 - b. The member must have received a minimum of at least 12 months of continuous hormonal gender reassignment unless contraindicated
 - c. The member must have completed at least 12 months of transgender real-life experience in the new or evolving gender role prior to surgical gender reassignment

- d. If required by the mental health professionals, the member must have had regular participation in psychotherapy throughout the real life experience at a frequency determined jointly by the patient and the mental health professionals
 - e. The member must have a complete physical examination including urogenital exam and blood chemistry within three months prior to initiation of surgical gender reassignment. Identified co-existing medical conditions must have been treated by procedures accepted as appropriate in the community and optimized prior to surgery.
- C. Readiness criteria:
1. The member must demonstrate progress in consolidating their gender identity
 2. The member must demonstrate progress in dealing with work, family, and interpersonal issues, resulting in improved states of mental health. For example, behavioral issues that may be present, such as sociopathy, substance abuse, psychosis, and suicidality, are satisfactorily controlled.
- D. If the member has a co-existing diagnosis of a mental disorder in addition to a diagnosis of gender dysphoria, the member must be optimally treated by procedures accepted as appropriate in the community for such non-transsexual psychiatric diagnosis, with symptoms controlled prior to requesting surgical gender reassignment. For example, there have been no episodes of inpatient care in the last year directly resulting from the coexisting condition.
- E. Written documentation from the medical record **is required**, including but not limited to:
1. Two letters of recommendation from: (1) a psychologist or psychiatrist who has and is currently treating the member and (2) a consulting psychologist or psychiatrist. Both letters must be dated not more than three months prior to the request for authorization. Each letter must contain:
 - a. The member's general identifying characteristics;
 - b. Results of the member's psychosocial assessment, including any diagnoses;
 - c. The duration of their professional relationship including the type of psychotherapy or evaluation that the member has undergone;
 - d. The eligibility and readiness criteria that have been met and the clinician's rationale for surgery, and
 - e. Whether the author of the report is part of a multi-disciplinary gender team
- F. The physician completing the physical examination must indicate in writing that there are no identified medical contraindications to surgical gender reassignment.
- G. Medica must receive all medical records pertaining to the diagnosis of gender dysphoria.
- H. A statement that informed consent has been obtained from the member.
- II. Contraindications
None of the following are present:
- A. Multisystem organ failure
 - B. Active systemic infection
 - C. Current substance abuse
 - D. Terminal illness.

COVERAGE ISSUES

1. Hormonal treatments for gender reassignment **do not require prior authorization**.
2. All services related to surgical gender reassignment **require prior authorization** by Medica, and review by a Medica medical director. The member must meet **all** medical necessity requirements for genital surgical gender reassignment for services to be authorized.
3. Coverage may vary according to the terms of the member's plan document.
4. For Medicare and Medicaid members, refer to the following, as applicable:
 - As of June 29, 2014, the Centers for Medicare and Medicaid Services (CMS) invalidated National Coverage Determination 140.3, Transsexual Surgery, which had excluded gender reassignment surgery from coverage. As a result, local contractors are obligated to consider whether any Medicare claims for these services are reasonable and necessary:
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R169NCD.pdf>. Accessed June 18, 2015.
 - Gender reassignment surgery is not a covered service under the programs of the Minnesota Department of Human Services (Medical Assistance):
<https://www.revisor.mn.gov/statutes/?id=256B.0625>. Accessed June 18, 2015.
5. Services eligible for coverage which are paid under the Mental Health section of the member's plan document, are subject to all service frequency and visit limitations described in that section of the member's plan document:
 - A. Pre-gender assignment counseling services

- B. Services of a licensed psychiatrist, or psychologist to diagnose and counsel the patient in the area of gender dysphoria
- C. Psychological/psychiatric evaluation
- D. Hormonal and Genital gender assignment counseling services (includes all counseling services immediately preceding and following surgical gender reassignment as well as the psychology consult for the second letter of recommendation)
- E. All mental health services provided to the member before, during and after initiation of hormonal therapy.
- 6. Services eligible for coverage paid according to the appropriate medical section of the member's coverage document, subject to all service frequency and visit limitations as outlined in the member's coverage document:
 - A. Pre-gender assignment medical evaluation
 - B. Hormonal gender assignment medical services. Includes all medical services directly related to the administration and monitoring of hormonal therapy
 - C. Genital surgical gender reassignment medical services
 - D. Pre-operation physical examination
 - E. Genital surgical gender reassignment inpatient and outpatient stays for eligible procedures
 - F. Includes all ambulatory follow-up care directly related to the genital surgical gender reassignment
 - G. Breast augmentation for male to female reassignment when all medical necessity criteria have been met
 - H. Mastectomy for female to male reassignment when all medical necessity criteria have been met.
- 7. Services not eligible for coverage:
 - A. Secondary sex change procedures (e.g., thyroid shaving, larynx change, electrolysis, liposuction of the waist, facial bone reduction, face-lift, blepharoplasty, etc.). If one of these procedures is being requested for a reason unrelated to gender reassignment, it is subject to all terms and conditions of the member's coverage document and must meet Medica's medical necessity requirements.
 - B. Services for the purpose of research or experimentation.
- 8. If the Medical Necessity and Coverage Criteria are met, Medica staff will authorize benefits within the limits in the member's plan document.
- 9. If it appears that the Medical Necessity and Coverage criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Medica Provider Administrative Manual.

DOCUMENT HISTORY

Original MPC Endorsement Date	October 1998
Subsequent MPC Endorsement Date(s)	10/1999, 09/2000, 06/2001, 06/2002, 07/2003, 06/2004, 06/2005, 06/2006, 06/2007, 06/2008, 06/2009, 06/2010, 06/2011, 06/2012, 06/2013, 09/2014, 9/2015.

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2. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. Arlington, VA. 2013.
3. Center for Medicare and Medicaid Services (CMS). Pub 100-03 Medicare National Coverage Determinations. Transmittal 169. Invalidation of National Coverage Determination 140.3 - Transsexual Surgery. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R169NCD.pdf>. Published June 27, 2014. Accessed July 7, 2014.
4. ECRI Institute. *Custom Hotline Response: Candidate Selection Criteria and Surgical Procedures for Treating Gender Identity Disorder*. April 2013. Plymouth Meeting, PA.
5. ECRI Institute. *Custom Hotline Response: Sexual Reassignment for Gender Identity Disorders*. December 2009. Plymouth Meeting, PA.
6. Gooren LJ. Care of transsexual persons. *N Engl J Med*. 2011;364:1251-1257.
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