| ADMINISTRATIVE POLICY AND PROCEDURE | | |
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| **Policy #:** | **1415 A** | |
| **Subject:** | **Gender Dysphoria and Transgender Surgery** | |
| **Section:** | **Care Management** | |
| **Effective Date:** | **02/01/2016** | |
| **Revision Date(s):** | | |
| **Review Date(s):** | **10/16** | |
| **Responsible Parties:** | **Patryce Toye, MD** | |
| **Responsible Department(s):** | **Utilization Management** | |
| **Regulatory References:** | **Department of Health and Mental Hygiene's (DHMH) policy for Gender Dysphoria Coverage as stated in Transmittal No. 110, dated March 10, 2016** | |
| **Approved:** | | |
| | **Carol Attia, RN<br>AVP, Care Management** | **Patryce A. Toye, MD<br>Senior Medical Director** |

Purpose: To define the conditions under which MedStar Family Choice will cover medications and approve surgical procedures to treat Gender Dysphoria.

Scope: MedStar Family Choice, Maryland.

Policy: It is the policy of MFC to authorize medically necessary medications and surgical procedures as outlined in the criteria below. This guideline is in accordance with Department of Health and Mental Hygiene's (DHMH) policy for Gender Dysphoria Coverage as stated in Transmittal No. 110, dated March 10, 2016. All requests require review by a Physician Advisor.

Background: MFC will follow the criteria outlined in DHMH Transmittal No. 110, which is based on The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Volume 7. Services available through MFC include medications and surgical procedures. Psychotherapy/mental health services are an important component of the overall care of this condition. In Maryland, mental health services are provided through the Medicaid behavioral health carve-out through the Department of Behavioral Health.

MFC will encourage all members to obtain care for Gender Dysphoria at a place of service with expertise in the care of this condition.

Definition: Gender Dysphoria, as defined in WPATH, refers to discomfort or distress that is 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). Only some gender-nonconforming people experience gender dysphoria at some point in their lives.

Procedure:

- Outpatient psychotherapy/mental health services will not require authorization.
- Inpatient psychiatric admissions will follow the standard authorization procedures for inpatient services.
- Requests for medical or surgical benefits should be submitted with appropriate medical and psychiatric records as well as letters of medical necessity when indicated by the policies outlined below.

**General Requirements:**

**For all Gender Dysphoria services, medical and surgical, candidates must**:

1) Be 18 years of age or older.
2) Have a clear diagnosis of gender dysphoria with presence of symptoms greater than 2 years.
3) Have the capacity to make fully informed decisions and consent for treatment.
4) Have no medical contraindications to treatment.
5) Have no psychiatric contraindications to treatment, including, but not limited to severe, uncontrolled comorbid psychiatric diseases with impaired reality testing.
6) Have been informed of non-covered related medical procedures/care and expected future medical procedures/care and any costs associated with them.
7) Express full understanding of the psychological, social, medical, and financial implications of treatment, for now and the future.

**Gender Reassignment Surgery Requirements:**

(Gender Reassignment Surgeries: orchiectomy, penectomy, clitoroplasty, labiaplasty, vaginoplasty, thyroid chondroplasty, vaginectomy, hysterectomy, mastectomy, salpingo-oophorectomy, ovariectomy, metoidioplasty, phalloplasty, scrotoplasty, placement of testicular prosthesis, and urethroplasty)

A. Medically necessary gender reassignment surgery procedures are covered for a male to female transition and a female to male transition. The details of the exact CPT codes for covered procedures are in Table 1.
B. Criteria for medical necessity of surgical procedures for gender reassignment surgery are as follows:
    a. **HORMONE THERAPY:** Individuals must have undergone a minimum of 12 months of continuous hormonal therapy as recommended by a mental health professional and provided under the supervision of a physician or an advanced practice nurse. If there is a contraindication to hormone therapy, it must be clearly

stated. Of note, hormonal therapy is not required as a prerequisite to a mastectomy.

b. **REAL LIFE EXPERIENCE:** There must be documentation that the individual has completed a minimum of 12 months of successful, continuous, substantially full-time real life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year. Of note, the real life experience is not required as a prerequisite to a mastectomy, augmentation mammoplasty, thyroid chondroplasty, hysterectomy, salpingo-oophrectomy, or orchiectomy).

c. **PSYCHOTHERAPY:** Regular participation in psychotherapy and/or ongoing clinical treatment throughout the real-life experience may be required when recommended by a treating medical or behavioral health practitioner or when medically necessary.

d. **OVERALL HEALTH STATUS:** If significant medical or mental health issues are present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing, (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder,) an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated or approved.

e. **REQUIRED MENTAL HEALTH ASSESSMENTS:** **Two** referrals from qualified mental health professionals who have independently assessed the individual will be required. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) will be required. At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., MD, Ed.D, D.Sc., DSW, or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two practitioners, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above. Of note, one letter signed by an appropriate practitioner is sufficient to support benefits for mastectomy.

   **Items that must be covered in the psychological assessment are as follows:**

   i. Duration the member has been in care with provider.
   ii. Results of the psychological assessment, including diagnoses.
   iii. Eligibility criteria should be met and discussed with intensive focus on the current status of any comorbid psychiatric disorders.
   iv. Statement of informed consent.
   v. Future treatment plans (leading up to surgery and long-term).
   vi. The start date of living full time in the new gender, when applicable.

f. **REQUIRED SURGEON ASSESSMENT:**

   **A letter of medical necessity from the treating surgeon must include**:

   i. A statement that the surgeon has communicated with the mental health professionals involved in the evaluation has read and understands the results of the psychological assessments, and that he/she feels that the member is an appropriate candidate for surgery.

ii. A statement that the member is aware of the ramifications of surgery including length of hospitalization, possible complications, and post-surgical rehabilitation requirements.

Limitations:

A. Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue, and sperm) and the charges associated therewith are not covered.
B. Additional coverage limitations are included in Table 1.
C. Procedures that are not specifically mentioned as covered and are generally considered as cosmetic will not be covered unless the procedure otherwise meets criteria for medical necessity. Procedure requested for esthetic improvement will not be covered.

**Table 1. Listing of Covered Services (assuming all criteria are met)**

| **CPT** | **Male to Female Genital Procedures** |
|---|---|
| 54520 | Orchiectomy |
| 54120 | Penectomy, partial |
| 56625<br>56633-40<br>55620<br>55630-32 | Labiaplasty (vulvectomy) |
| 56805 | Clitoroplasty for intersex state |
| 57335 | Vaginoplasty for intersex state |
| 19325 | Breast Augmentation Mammoplasty, augmentation; with prosthetic implant<br><br>Augmentation mammoplasty (including breast prosthesis if necessary) may be covered for male-to-female transgender individuals if the physician prescribing hormones and the treating surgeon have documented that, after undergoing hormone treatment for 12 months, breast sized continues to cause clinically significant distress in social, occupational, or other areas of functioning. |
| 19350 | Nipple/areola reconstruction in connection with a covered augmentation mammoplasty (not covered in isolation) |
| **CPT** | **Female to Male Genital Procedures** |
| 57106 | Vaginectomy; partial removal of vaginal wall |
| 58720 | Salpingo-oophorectomy |
| 58700<br>58720<br>58150<br>58940 | Oophorectomy |
| 58150<br>58550<br>58552-4<br>58180<br>58262<br>58275<br>58290-1<br>58541-4 | Hysterectomy |

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| 58570-3 | |
| 19301<br>19303-4 | Mastectomy |
| 19324-5 | Breast enlargement procedures in connection with a covered augmentation mammoplasty (not covered in isolation) |
| 19350 | Nipple/areola reconstruction in connection with a covered mastectomy (not covered in isolation) |
| 55899 | Metoidioplasty |
| 55899 | Phalloplasty |
| 54400 | Penile prosthesis (non-inflatable/inflatable) in connection with a covered phalloplasty (implantation of the prosthesis shall not be considered a second stage phalloplasty) in female-to-male transition (subsequent replacement of correction of such prosthesis is subject to rules and limitations applicable to all prosthetic devices) |
| 55175 | Scrotoplasty, simple |
| 55180 | Scrotoplasty, complex |
| 54660 | Placement of Testicular Prosthesis |
| 54660 | Testicular expanders as a component of a covered placement of a testicular prosthesis |
| 53430 | Urethroplasty<br>Urethroplasty, reconstruction of female urethra |
| | **Non-Genital, Non-Breast Surgeries** |
| 21899 | Thyroid Chondroplasty |

## Table 2. SERVICES THAT ARE NOT COVERED

| **Non-Genital, Non-Breast Surgeries** |
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| Brow lift |
| Cheek implants |
| Chin/nose implants |
| Lip reduction/enhancement |
| Collagen injections |
| Electrolysis |
| Facial bone reconstruction |
| Face/forehead lift |
| Hair removal/hairplasty/hair transplantation |
| Jaw shortening/sculpturing/facial bone reduction |
| Liposuction |
| Neck tightening |
| Reversal of genital or breast surgery or reversal of surgery to revise secondary sex characteristics |
| Voice modification surgery |
| Voice therapy/voice lessons |
| Rhinoplasty |
| Removal of redundant skin, except in connection with a covered surgery |
| Replacement of tissue expander with permanent prosthesis testicular insertion, except as a component of a covered placement of a testicular prosthesis |
| Second stage phalloplasty |
| Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis |

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| (subsequent replacement or correction of such prosthesis is subject to rules and limitations applicable to all prosthetic devices |
| Blepharoplasty |
| Laryngoplasty |
| Abdominoplasty |

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| **Summary of Changes:** | **10/16:**<br>• No changes<br>**02/16:**<br>• New policy |

http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926