MedStar Family Choice

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**1415**	
Subject:	**Gender Dysphoria and Transgender Surgery**	
Section:	**Medical Non-Pharmacy Protocols**	
Initial Effective Date:	**02/01/2016**	
Revision Effective Date(s):	**07/18, 07/19, 07/20**	
Historical Revision Date(s):	**07/17**	
Review Effective Date(s):		
Historical Review Date(s):	**10/16**	
Responsible Parties:	**Patryce Toye, MD**	
Responsible Department(s):	**Utilization Management**	
Regulatory References:	**Maryland Department of Health's (MDH) policy for Gender Dysphoria Coverage as stated in Transmittal No. 110, dated March 10, 2016**	
Approved:	**Theresa Bittle, RN** **AVP, Clinical Operations**	**Patryce A. Toye, MD** **Chief Medical Officer**

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

Scope: **MedStar Family Choice**

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 Maryland Department of Health's (MDH) policy for Gender Dysphoria Coverage as stated in Transmittal No. 110, dated March 10, 2016. All requests require review by a Medical Director.**

Background:

MFC will follow the criteria outlined in MDH 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:

1. Outpatient psychotherapy/mental health services will not require authorization.

2. Inpatient psychiatric admissions will follow the standard authorization procedures for inpatient services.

3. 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.

A. General Requirements:
   1. For all Gender Dysphoria services, medical and surgical, candidates must:
      a. Be 18 years of age or older.
      b. Have a clear diagnosis of gender dysphoria with presence of symptoms greater than 2 years.
      c. Have the capacity to make fully informed decisions and consent for treatment.
      d. Have no medical contraindications to treatment.
      e. Have no psychiatric contraindications to treatment, including, but not limited to severe, uncontrolled co-morbid psychiatric diseases with impaired reality testing.
      f. Have been informed of non-covered related medical procedures/care and expected future medical procedures/care and any costs associated with them.
      g. Express full understanding of the psychological, social, medical, and financial implications of treatment, for now and the future.

B. 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)

1. 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.

2. 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-oophorectomy, 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.
        i. Items that must be covered in the psychological assessment are as follows:
            1. Duration the member has been in care with provider.
            2. Results of the psychological assessment, including diagnoses.
            3. Eligibility criteria should be met and discussed with intensive focus on the current status of any co-morbid psychiatric disorders.
            4. Statement of informed consent.

5. Future treatment plans (leading up to surgery and long-term).
6. The start date of living full time in the new gender, when applicable.

f. Required Surgeon Assessment:
    i. A letter of medical necessity from the treating surgeon must include:
        1. 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.
        2. A statement that the member is aware of the ramifications of surgery including length of hospitalization, possible complications, and post-surgical rehabilitation requirements.

C. Covered Procedures:

1. Only procedures listed in Table 1 are covered.

D. Limitations (not covered)

1. Coverage limitations are included in Table 2.

2. Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue, and sperm) and the charges associated therewith are not covered.

3. Procedures requested for esthetic improvement will not be covered.

Table 1: Listing of Covered Services (Assuming All Criteria Are Met)

Male to Female Transition	Suggested Code	Code Description
Labiaplasty	14040 14041	adjacent tissue transfer or rearrangement genitalia 10 sq. cm or less 10.1 sq. cm to 30.0 sq. cm
Breast enlargement procedures	19324 19325	w/o implant with implant
Thyroid Chondroplasty	31899	unlisted procedure, trachea, bronchi
Urethroplasty	53430 53410	Urethroplasty, reconstruction of female urethra Urethroplasty, 1 stage reconstruction of male anterior urethra
Penectomy (penile inversion)	54120	Partial Penectomy
Orchiectomy	54520	Orchiectomy, simple w or w/o prosthesis
Clitoroplasty	56805	Clitoroplasty for intersex state
Vaginoplasty	57335	Vaginoplasty for intersex state
Female to Male Transition	**Suggested Code**	**Code Description**
Mastectomy	19301 19303	partial simple, complete
Nipple/areola reconstruction in connection w/covered mastectomy	19350	
Urethroplasty	53410 53430	Urethroplasty, 1 stage reconstruction of male anterior urethra Urethroplasty, reconstruction of female urethra
Insertion of penile prosthesis; non-inflatable (semi-rigid)	54400	
Insertion of penile prosthesis; inflatable (self-contained)	54401	
Insertion of multicomponent penile prosthesis, including	54405	

placement of pump, cylinders and reservoir. All must be inserted in connection with a covered phalloplasty		
Placement of Testicular Protheses	54660	Insertion of testicular prosthesis (separate procedure)
Scrotoplasty	55175 55180	simple complex
Metoidioplasty	55899	unlisted procedure, male genital system
Vaginectomy	57106 57110 57111	partial removal of vaginal wall complete removal of vaginal wall complete removal of vaginal wall with removal of paravaginal tissue
Hysterectomy:	58150 58180 58260 58262 58275 58290 58291 58541 58542 58543 58544 58550 58552 58553 58554 58570 58571 58572 58573	
Vulvectomy	56620	Simple; partial
Salpingo-oophorectomy	58720	
Oophorectomy	58940	
Phalloplasty	55899 13132	unlisted procedure, male genital system Complex Repair forehead, cheeks, chin, mouth, neck, axillae,

		genitalia, hands and/or feet; 2.6cm to 7.5cm
	13160	Secondary closure of surgical wound or dehiscence, extensive or complicated
	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1sq cm to 30.0sq cm
	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10sq cm or less
	14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10.1sq. cm to 30.0sq. cm
	14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1-60sq cm
	14302	Adjacent tissue transfer or rearrangement, any area; each additional 30sq cm or part thereof (list separately in addition to code for primary procedure)
	15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release or scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100sq. cm
	15100	Split-thickness autograft, trunk, arms, legs; first 100sq. cm or less,
		Skin Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears,

	15120	orbits, genitalia, hands, feet, and/or multiple digits; first 100sq cm or less
	15240	Skin Full Thickness Graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20sq cm or less
	15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100sq cm; first 100sq cm wound surface area
	15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100sq cm; each additional 100sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
	15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
	15750	Neurovascular Pedicle Flap (skin and subcutaneous tissue containing a neurovascular link is trimmed for use as an island pedicle flap. The extra tissue is removed from the pedicle so that the connection to the donor site is little more than an innervated artery and vein. A defect is covered by elevation of a flap of skin and subcutaneous tissue from a nearby but not immediately adjacent donor site. The flap involves an anatomically named blood vessel in its creation. Often this tissue is transferred through a tunnel underneath the skin and sutured into its new position. The donor site is closed directly. Report 15750 if the pedicle is neurovascular, containing nerve and blood vessel elements
		Free muscle or myocutaneous flap with microvascular anastomosis

	15756 15757 15777 64856 64857 64859	Free Skin Flap with Microvascular anastomoses Implantation of biologic implant (e.g. acellular dermal matrix) for soft tissue reinforcement Suture of major peripheral nerve, arm or leg, except sciatic; including transposition Suture of major peripheral nerve, arm or leg, except sciatic; without transposition Suture of each additional major peripheral nerve (list separately in addition to code for primary procedure)

Table 2: Services That Are Not Covered

Non-Genital, Non-Breast Surgeries
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 phalloplasty or enhancement procedures
Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis (subsequent replacement or correction of such prosthesis is subject to rules and limitations applicable to all prosthetic devices)
Blepharoplasty
Laryngoplasty
Abdominoplasty
Mastopexy

References

https://www.wpath.org/publications/soc

Summary of Changes:	**07/20:** • Table 1, Section Female to Male: Removal of CPT 19304 mastectomy subcutaneous because code retired from use. **07/19:** • Removal of "A" from policy number. • Removal of "Maryland" from scope. • Updated Table 1: Listing of Covered Services (Assuming All Criteria Are Met). **07/18:** • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates;

	and added Historical Review Dates and Review Effective Dates. **07/17:** • Changed Carol Attia to Theresa Bittle and updated Dr. Patryce Toye's title from Senior Medical Director to Chief Medical Officer. • Added MFC. • Changed Physician Advisor to Medical Director. • Changed DHMH to MDH. **10/16:** • No changes. **02/16:** • New policy.