TUFTS Health Plan

Medical Necessity Guidelines: Gender Affirming Services

Effective: June 15, 2022

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☒ Tufts Health Plan Commercial products; Fax: 617.972.9409

- CareLink[SM] – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*****The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Gender Affirming services, which can involve various reconstruction surgeries, are part of the treatment approach for individuals with gender dysphoria (GD)/gender incongruence who have persistent feelings of gender discomfort and inappropriateness of their anatomical sex. Surgical procedures may include reconstruction to physical appearance and function of an individual's existing sexual characteristics.

Gender dysphoria/gender incongruence involves a difference between one's gender identity and sex designated at birth (usually based on external sexual anatomy). Gender dysphoria/gender incongruence is not the same as gender nonconformity, which refers to behaviors not matching the gender norms or stereotypes of the gender assigned at birth.

CLINICAL COVERAGE CRITERIA

Genital Surgery Clinical Coverage Criteria

The Plan considers gender affirming surgical services as medically necessary when documentation and letters confirm **ALL** the following for gender affirming **genital surgery**:

1. Member has been diagnosed with gender dysphoria/gender incongruence by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field; **AND**
2. Member has the capacity to make fully informed decisions and to consent to treatment; **AND**
3. If significant medical or mental health concerns are present, they must be well controlled; **AND**
4. Member has completed 12 continuous months of hormone therapy appropriate to the member's desired gender (unless medically contraindicated);
5. Member has lived as their affirmed gender full-time for 12 months or more. (Numbers 4 and 5 may occur concurrently.)

Masculinizing Gender Affirming Procedures

- Genital Surgery
  - Hysterectomy
  - Salpingo-oophrectomy
  - Vulvectomy
  - Vaginectomy
  - Urethroplasty
  - Metoidioplasty
  - Phalloplasty
  - Scrotoplasty with placement of testicular prostheses

Feminizing Gender Affirming Procedures

- Genital Surgery
  - Penectomy
  - Clitoroplasty
  - Colovaginoplasty
  - Vulvoplasty
  - Labiaplasty
  - Orchiectomy
  - Vaginoplasty

Chest Surgery Clinical Coverage Criteria

The Plan considers gender affirming surgical services as medically necessary when documentation and letters confirm ALL the following for gender affirming **breast/chest surgery**:

1. Member has been diagnosed by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field with gender dysphoria/gender incongruence; AND
2. Member has the capacity to make fully informed decision and to consent for treatment; AND
3. If significant medical or mental health concerns are present, they must be well controlled; AND
4. Member has lived as their affirmed gender full-time for 12 months or more; AND
5. Gender affirming surgery has been recommended by TWO treating clinicians

Masculinizing Gender Affirming Procedures

- Breast/Chest Surgery
  - Mastectomy (bilateral)

Feminizing Gender Affirming Procedures

- Breast/Chest Surgery
  - Mammoplasty (breast augmentation)

Facial Feminization or Masculinization Surgeries

The Plan considers gender affirming surgical services as medically necessary when documentation and letters confirm ALL of the following for gender affirming **facial surgery**

1. Member has been diagnosed by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field with gender dysphoria/gender incongruence; AND
2. Member has the capacity to make fully informed decision and to consent for treatment; AND
3. If significant medical or mental health concerns are present, they must be well controlled; AND
4. Member has lived as their affirmed gender full-time for 12 months or more; AND
5. Gender affirming surgery has been recommended by TWO treating clinicians

- Blepharoplasty
- Brow Lift
- Cheek Augmentation

- Forehead and mandible/jaw contouring and reduction
- Genioplasty
- Hairline advancement
- Lateral canthopexy
- Lip lift
- Lysis intranasal synechia
- Osteoplasty
- Rhinoplasty
- Septoplasty
- Suction assisted lipectomy
- Tracheoplasty
- Rhytidecomy
- Reduction thyroid chondroplasty

Hair Removal for Face/Neck

The plan considers hair removal by laser or electrolysis for the face and neck as medically necessary when documentation and letters confirm **ALL** of the following:

1. Member has been diagnosed by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field with gender dysphoria/gender incongruence; **AND**
2. Member has the capacity to make fully informed decision and to consent for treatment; **AND**
3. If significant medical or mental health concerns are present, they must be well controlled; **AND**
4. Member has completed 12 continuous months of hormone therapy appropriate to the member's desired gender (unless medically contraindicated)
5. Member has lived as their affirmed gender full-time for 12 months or more; **AND**
6. Hair removal for face and/or neck has been recommended by a board-certified dermatologist or licensed treating provider

Hair Removal for Genital Surgery

The plan considers hair removal by laser or electrolysis for planned gender affirming surgical services as medically necessary when documentation and letters confirm **ALL** of the following:

1. Member has been diagnosed by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field with gender dysphoria/gender incongruence; **AND**
2. Member has the capacity to make fully informed decision and to consent for treatment; **AND**
3. If significant medical or mental health concerns are present, they must be well controlled; **AND**
4. Member has completed 12 continuous months of hormone therapy appropriate to the member's desired gender (unless medically contraindicated)
5. Member has lived as their affirmed gender full-time for 12 months or more; **AND**
6. Hair removal for genital surgery has been recommended by a board-certified dermatologist or licensed treating provider **AND**
7. Prior authorization must be obtained for gender affirming surgery prior to request for hair removal.

Note: Documentation must include a letter of medical necessity by the treating surgeon, indicating the size and location of the area to be treated, a timeline with the expected number of treatments and expected date of planned genital surgery.

Speech Therapy

The plan considers voice modification and communication therapy for definitive diagnosis of persistent gender dysphoria as medically necessary for development of vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g. facial expressions, laughing) that are congruent with the member's gender identity and/or gender expression

Note:

- Covered procedures must be performed by qualified providers trained in treating individuals with gender dysphoria/gender incongruence.
- Subsequent revisions of these procedures to improve appearance will be considered cosmetic and therefore not medically necessary.

LIMITATIONS

The plan does not cover the reversal of any of the procedures listed above.

The plan considers all other services for the treatment of gender dysphoria/gender incongruence as not medically necessary for all other indications. In addition, the plan does not cover:

- Body contouring procedures e.g., abdominoplasty, breast contouring, suction assisted lipoplasty, liposuction or lipofilling
- Collagen injections
- Dermabrasion
- Chemical peels
- Electrolysis or hair removal except for face/neck and when required pre-operatively for genital surgery and when policy criteria are met
- Reversal of transgender health services and all related drugs and procedures
- Hair transplantation
- Implantations (e.g., calf, pectoral, gluteal)
- Liposuction
- Panniculectomy
- Removal of redundant skin
- Silicone injections (e.g., for breast enlargement)
- Vocal Cord surgery for voice modification
- Reimbursement for travel expenses

CODES

Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

CPT® Code	Description
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid

CPT® Code	Description
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15876	Suction assisted lipectomy; head and neck
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19318	Breast Reduction
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

CPT® Code	Description
31599	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54120	Amputation of penis; partial
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57106	Vaginectomy, partial removal of vaginal wall;
57110	Vaginectomy, complete removal of vaginal wall;
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less;

CPT® Code	Description
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal or adnexal structures (partial or total oophorectomy and/or salpingectomy
58720	Salpino-oophorectomy, complete or partial, unilateral or bilateral (separate procedures)
58940	Oophorectomy, partial or total, unilateral or bilateral;
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

The following ICD-10-CM diagnosis codes require prior authorization when they are being performed with any of the CPT Codes listed above

ICD-10-CM Codes	Description
F64-F64.9	Gender identity disorder
Z87.890	Personal history of sex reassignment

REFERENCES

1. National Center for Gender Equality. Understanding Transgender People: The Basics. July 9, 2016. Transequality.org/issues/resources/understanding-transgender-people-the-basics. Accessed March 8, 2021.
2. The World Professional Association for Transgender Health. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. The World Professional Association for Transgender Health; 2011. wpath.org/publications/soc. Accessed March 8, 2021.

3. Committee on Health Care for Underserved Women. Committee Opinion no. 512: health care for transgender individuals. Obstet Gynecol. 2011;118(6):1454-1458. doi:10.1097/AOG.0b013e31823ed1c1.
4. UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. transcare.ucsf.edu/guidelines. Accessed March 15, 2021.
5. Sex Reassignment Surgery for the Treatment of Gender Dysphoria. Hayesinc.com/login [via subscription only]. Published August 1, 2018. Updated August 22, 2019. Accessed March 8, 2021.
6. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in J Clin Endocrinol Metab. 2018 Feb 1;103(2):699] [published correction appears in J Clin Endocrinol Metab. 2018 Jul 1;103(7):2758-2759]. J Clin Endocrinol Metab. 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658.
7. Karasic DH, Fraser L. Multidisciplinary Care and the Standards of Care for Transgender and Gender Nonconforming Individuals. Clin Plast Surg. 2018;45(3):295-299. doi:10.1016/j.cps.2018.03.016.
8. Centers for Medicare and Medicaid Services. National Coverage Determination for Gender Dysphoria and Gender Reassignment Surgery (140.9) cms.gov/medicare-coverage-database/details/ncd-details.aspx?ncdid=368&bc=CAAAAAAAAAAA. Accessed March 15, 2021.

APPROVAL HISTORY

April 10, 2013: This coverage guideline was reviewed by the Integrated Medical Policy Advisory Committee (IMPAC) for an effective date of July 1, 2013.

Subsequent endorsement date(s) and changes made:

- December 11, 2013: Reviewed by IMPAC, renewed without changes.
- September 10, 2014: Reviewed by IMPAC, title change; added list of non-covered cosmetic procedures to Limitations section; added code and description of additional covered surgical procedure: 54660, insertion of testicular prosthesis; wording clarifications including deletion of term and definition gender dysphoria. Effective January 1, 2015.
- October 8, 2014: Reviewed by IMPAC, eliminated language requiring documentation of compliance, type, frequency, and route of hormone therapy. Effective January 1, 2015.
- December 10, 2014: Reviewed by IMPAC, renewed without changes
- January 1, 2015: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- May 13, 2015: Reviewed by IMPAC, limitations language updated including additions for voice therapy, vocal cord surgery for voice modification, and permanent hair removal with an effective date of October 1, 2015. Coverage Guidelines updated with wording changes and bullet number one concerning age removed.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- October 14, 2015: Reviewed by IMPAC, renewed without changes
- November 30, 2015: Added Rhode Island to Note section.
- March 25, 2016: Coding updated; ICD-9-CM codes removed
- April 13, 2016: Reviewed by IMPAC, renewed without changes
- June 20, 2016: Reviewed by IMPAC, renewed without changes
- October 24, 2016: Reviewed by IMPAC, continuous hormone therapy and mastectomy related hormone criterions clarified. Effective April 1, 2017: Limitation for hair removal clarified (link added for the Medical Necessity Guidelines: Reconstructive and Cosmetic Surgery).
- February 8, 2017: Reviewed by IMPAC, effective July 1, 2017, Tufts Health Together product will have a separate Medical Necessity Guideline.
- April 12, 2017: Reviewed by IMPAC, renewed without changes
- July 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- August 31, 2017: Coding updated.
- September 13, 2017: Reviewed by IMPAC, renewed without changes
- January 24, 2018: Administrative update
- March 14, 2018: Reviewed by IMPAC, renewed without changes
- September 12, 2018: Reviewed by IMPAC, CPT code 19350 added to code tables for Male to Female Surgery and Female to Male Surgery.
- October 2018: Template and disclaimer updated

- December 12, 2018: Reviewed by IMPAC, procedures for feminization and masculinization added effective 2/1/2019.
- March 20, 2019: Reviewed by IMPAC, renewed without changes
- January 1, 2020: Coding updated. Per AMA CPT®, effective January 1, 2020 the following code(s) removed: 19304; the following code added: 15769
- June 17, 2020: Reviewed by IMPAC, renewed with no changes
- June 30, 2020: Fax number for Unify updated
- October 21, 2020: Reviewed by IMPAC. In clinical coverage criteria, clarified treating providers includes both medical and/or surgical providers. The following codes added: 58570, 15771, 15772, 67900
- March 17, 2021: Reviewed by IMPAC. Terminology change from gender reassignment surgery or sexual reassignment surgery to gender affirmation or confirmation surgery; references updated
- June 16, 2021: Reviewed by IMPAC. Under Limitations, changed "Body contouring procedures" to "Body changes not associated with gender transition procedures"
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC) for integration purposes with Harvard Pilgrim Health Care with an effective date of September 1, 2021. Title change to Gender Affirming Services and new criteria added for speech therapy, hair removal from face/neck, etc. Codes added: 11970, 11971, 15876, 21208, 21210, 30520, 31750, 54400, 54401, 54405 and 55866 removed. Public plans to follow this policy and the Medical Necessity Guidelines for Transgender Surgical Procedures for Tufts Health Together and Tufts Health RITogether will be retired.
- February 1, 2022: Template Updated
- June 15, 2022: Reviewed by MPAC for an effective date of October 1, 2022. Addition of gender affirming genital surgery recommended by two treating clinicians and breast/chest surgery recommend by one treating clinician. Addition of codes 55980, 40799, and 21282

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services