Medical Necessity Guidelines: Transgender Surgical Procedures

Effective: February 1, 2019

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
☒Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – 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: 781.393.2607
*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.

Note: This guideline is used to determine coverage of transgender services for Members on Massachusetts and Rhode Island fully insured Products, and for those Members whose plan document includes this benefit.

OVERVIEW

Transgender is a broad term that can be used to describe people whose gender identity is different from the gender they were thought to be when they were born (National Center for Transgender Equality[4]).

The term gender reassignment surgery or sexual reassignment surgery may be used to mean either the reconstruction of male or female genitals, specifically, or the reshaping, by any surgical procedure of a male body into a body with female appearance, or vice versa. Gender reassignment surgery is part of a treatment plan for gender identity dysphoria (World Professional Association for Transgender Health[5]).

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize the coverage of transgender surgery procedures listed in this guideline for Members who have this benefit included in their plan document when **ALL** of the following criteria are met:

1. The Member has a definitive diagnosis of persistent gender dysphoria that has been made and documented by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field
2. The Member has received continuous hormone therapy for 12 months or more under the supervision of a physician. Exceptions: The Member has a medical contraindication that is attested to by the treating endocrinologist; or when the request is mastectomy only for female to male surgery.
3. The Member has lived as their reassigned gender full-time for 12 months or more. (Numbers 2 and 3 may occur concurrently.)
4. The Member's medical and mental health providers document that there are no contraindications to the planned surgery and agree with the plan (within three months of the Prior Authorization request).

Covered Surgical Procedures for Gender Reassignment for the Treatment of Persistent Gender Dysphoria

When the above guidelines are met, Tufts Health Plan may authorize one or more of the following covered surgeries, up to the Member's benefit limit:

- Male-to-Female Procedures
  - Penectomy
  - Orchiectomy
  - Vaginoplasty
  - Clitoroplasty
  - Labiaplasty
  - Vulvoplasty
  - Mammaplasty (breast augmentation)
  - Prostatectomy
  - Urethroplasty
- Female-to-Male Procedures
  - Mastectomy
  - Hysterectomy
  - Salpingectomy
  - Oophorectomy
  - Vaginectomy
  - Vulvectomy
  - Metoidioplasty
  - Phalloplasty
  - Urethroplasty
  - Scrotoplasty
- Feminization or Masculinization Procedures
  - Facial bone reduction
  - Blepharoplasty
  - Rhinoplasty
  - Rhytidectomy
  - Osteoplasty
  - Genioplasty
  - Forehead or cheek augmentation
  - Mandible/jaw contouring
  - Reduction thyroid chondroplasty

NOTE: Subsequent revisions of these procedures to improve appearance will be considered cosmetic and therefore not medically necessary.

LIMITATIONS

Tufts Health Plan does not cover the reversal of any of the procedures listed above.

Tufts Health Plan does not cover the procedures listed below performed for the purpose of transgender surgery because they are considered cosmetic for all Members (this list may not be all-inclusive):

- Body contouring procedures, e.g., abdominoplasty, breast contouring, suction-assisted lipoplasty, liposuction or lipofilling
- Vocal Cord surgery for voice modification
- Voice Training
- Hair removal, except as indicated in the Medical Necessity Guidelines: Reconstructive and Cosmetic Surgery.

CODES

Note: The following codes are informational; this may not be an all-inclusive list.

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

For Male to Female Surgery:
Prior Authorization is required for intersex surgery, CPT 55970.

CPT Codes	Description
55970	Intersex surgery, male to female

This procedure may include one or more of the following procedures. These require prior authorization.

CPT Codes	Description
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
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
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state (female procedure)
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

For Female to Male Surgery:
Prior Authorization is required for intersex surgery, CPT 55980.

CPT Codes	Description
55980	Intersex surgery, female to male

This procedure may include one or more of the following procedures. These require prior authorization.

CPT Codes	Description
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19350	Nipple/areola reconstruction
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
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
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
56625	Vulvectomy simple; complete

CPT Codes	Description
57106	Vaginectomy, partial removal of vaginal wall
57110	Vaginectomy, complete removal of vaginal wall
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 grams or less;
58262	Vaginal hysterectomy, for uterus 250 grams 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 grams;
58291	Vaginal hysterectomy, for uterus greater than 250 grams; 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 grams or less;
58552	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams 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 grams; with removal of tube(s), and/or ovary(s)
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 250 g or less
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 lysis of adhesions (salpingolysis, ovariolysis) (separate procedure): with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral

Feminization/Masculinization Procedures:

The following codes require prior authorization:

CPT Codes	Description
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
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
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck

CPT Codes	Description
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, 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
21209	Osteoplasty, facial bones; reduction
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)
31599	Unlisted procedure, larynx (can be used for reduction of thyroid cartilage)

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

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9. Centers for Medicare and Medicaid Services. Palmetto GBA. Local Coverage Article: Gender reassignment services for gender dysphoria (A53793). Last accessed March 14, 2018

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.

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.