

**Policy: MP307**

**Section: Medical Benefit Policy**

**Subject: Gender Dysphoria and Gender Confirmation Treatment**

### Applicable Lines of Business

|                   |          |             |          |
|-------------------|----------|-------------|----------|
| <b>Commercial</b> | <b>X</b> | <b>CHIP</b> | <b>X</b> |
| <b>Medicare</b>   | <b>X</b> | <b>ACA</b>  | <b>X</b> |
| <b>Medicaid</b>   | <b>X</b> |             |          |

### I. Policy: Gender Dysphoria and Gender Confirmation Treatment

#### II. Purpose/Objective:

To provide a policy of coverage regarding gender dysphoria and gender confirmation treatment

#### III. Responsibility:

- A. Medical Directors
- B. Medical Management

#### IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

#### V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

#### Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an

illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

## **Gender Dysphoria and Gender Confirmation Treatment:**

### **REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE**

#### **The following services are covered:**

##### **1. Psychological Evaluation and Treatment**

The following are covered:

- Psychological evaluation and Psychotherapy (if mental health services are included in the plan design) for gender dysphoria and associated co-morbid psychiatric diagnoses.

##### **2. Medical Treatment**

### **Continuous Hormonal Therapy**

(This section is provided as informational only to outline the current standards for hormonal therapy. Please see any applicable Pharmacy benefit documents for specific coverage.)

**Pre-pubertal** - no medical treatment

**Peri-pubertal** – gonadotropin-releasing hormone (GnRH) analogs to achieve suppression of pubertal hormones may be considered once the member reaches Tanner Stage\* 2

\*The Tanner Scale is measurement of physical development in children, adolescents and adults.

[http://www.childgrowthfoundation.org/CMS/FILES/Puberty\\_and\\_the\\_Tanner\\_Stages.pdf](http://www.childgrowthfoundation.org/CMS/FILES/Puberty_and_the_Tanner_Stages.pdf)

- Between 14 – 16 yrs of age –pubertal development of the desired opposite sex can be using a gradually increasing dose schedule of cross-gender hormone.
- Adolescents should be treated with GnRH analogues, progestins (e.g., medroxyprogesterone) or other medications that block and/or neutralize testosterone, estrogens and progesterone secretion.

**Post-pubertal** – continuous hormone replacement therapy

- Female to male: IM testosterone or topical testosterone
- Male to female: Anti-androgen therapy (e.g., Spironolactone, GnRH agonists, plus estrogen
  - Age 40 yrs or older – estrogen cream, patch or injectable

### **Prevention and Long-term Care**

Clinical and laboratory monitoring every 3 months during the first year and then once yearly unless otherwise indicated

- prolactin levels in male-to-female members treated with estrogens
- evaluation for cardiovascular risk factors.
- bone mineral density measurements if risk factors for osteoporosis exist

For female to male members: Age-appropriate screening for breast cancer and cervical cancer should be continued unless mastectomy or removal of the cervix has occurred.

For male to female members: Age-appropriate screening for breast and prostate cancer screening as necessary.

##### **3. Surgical Treatment**

Gender confirming services may be considered medically necessary when supporting documentation is provided by the clinicians (physicians and mental health professionals) confirms **ALL** of the following:

- The member is 18 years of age or older \*; and
- The member has been diagnosed with Gender Dysphoria; and
- The member has expressed a desire to transition his/her body to the preferred gender through surgery and hormone replacement therapy\*\* (if not otherwise contraindicated); and

- The member has completed a psychological assessment (psychotherapy may be recommended, but is not required) by a mental health professional who works with adults presenting with gender dysphoria:
  1. A master's degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country; and
- If considering vaginoplasty or phalloplasty, the member has completed a twelve (12) month period of full-time experience functioning in the desired gender role; and
- A medical evaluation has been completed by a MD/DO; and
- The gender confirming surgery has been recommended by:
  - "One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty)"; or
  - "Two referrals—from qualified mental health professionals who have independently assessed the patient—are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient".

WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People v. 7

\*Note: Per WPATH guidelines, "Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression."

\*\*Note: hormone therapy is not required when the requested surgery is solely a mastectomy for purposes of female to male gender confirmation.

The following surgical services are considered medically necessary for gender transition:

| Male to female transition               | Female to male transition                                       |
|---|---|
| Penectomy                               | Mastectomy (subcutaneous mastectomy or simple/total mastectomy) |
| Orchiectomy                             | Nipple/areola reconstruction related to mastectomy              |
| Vaginoplasty                            | Penile prostheses   |
| Labiaplasty                             | Salpingo-oophorectomy   |
| Clitoroplasty                           | Scrotoplasty  |
| Breast augmentation                     | Testicular prostheses   |
| Colovaginoplasty                        | Urethroplasty   |
| Voice therapy                           | Vaginectomy   |
| Electrolysis of vaginoplasty donor site | Metoidoplasty   |
| Laryngoplasty                           | Colpectomy  |
| Voice modification surgery              | Hysterectomy  |
| Voice/speech therapy                    | Phalloplasty  |
| Urethroplasty                           | Electrolysis of phalloplasty donor site                         |

**EXCLUSIONS:** The following procedures are considered to be cosmetic and not medically necessary to complete gender transition:

- Blepharoplasty (unless criteria per MP10 are met apart from gender reassignment)
- Rhinoplasty (unless criteria per MP204 are met apart from gender reassignment)
- Collagen injections
- Electrolysis (other than noted above)
- Rhytidectomy (i.e. face lift)
- Facial implants, injections, or bone reduction (may be considered on a per-case basis with appropriate clinical documentation)
- Hair removal (except as noted in the MtF indication tables)
- Hair transplantation
- Medication to promote hair growth
- Lip reduction or enhancement

- Liposuction
- Removal of redundant skin (unless criteria per MP56 are met apart from gender reassignment)
- Silicone injections
- Body sculpting (e.g., masculinization or feminization of torso, body contouring, gluteal augmentation, etc.)

Reversal of genital surgery is **NOT COVERED**.

Reversal of surgery to revise secondary sex characteristics is **NOT COVERED**.

Revision of surgical procedures in the absence of evidence of physiologic dysfunction is **NOT COVERED**.

In the absence of contract-specific benefits, procedures for the preservation of fertility ( e.g., procurement, cryopreservation and storage of sperm, oocytes or embryos) is **NOT COVERED**.

### **Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis

**Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.**

**CODING ASSOCIATED WITH:** Gender confirmation

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.*

- 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; 50 cc or less injectate or part thereof
- 15773 Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands and/or feet; 25 cc or less injectate
- 15774 Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands and/or feet; 25 cc or less injectate or part thereof
- 17380 Electrolysis
- 19301 Mastectomy
- 19303 Mastectomy, simple, complete
- 19304 Mastectomy, subcutaneous
- 19316 Mastopexy
- 19318 Reduction mammoplasty
- 19324 – Mammoplasty, augmentation; without prosthetic implant
- 19325 – Mammoplasty, augmentation, with prosthetic implant
- 19340 Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
- 19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
- 19350 – Nipple/areola reconstruction
- 19357 – Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
- 19361 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
- 19364 Breast reconstruction with free flap
- 19366 Breast reconstruction with other technique
- 19367 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site
- 19368 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
- 19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
- 19371 Periprosthetic capsulectomy, breast
- 19380 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

- 31587 – Laryngoplasty, cricoid split
- 53400 Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg. Johanssen type)
- 53405 Urethroplasty; second stage (formation of urethra), including urinary diversion
- 53410 Urethroplasty, 1-stage reconstruction of male anterior urethra
- 53415 – Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
- 53420 – Urethroplasty, 2-stage reconstruction or repair off prostatic or membranous urethra; first stage
- 53425 - Urethroplasty, 2-stage reconstruction or repair off prostatic or membranous urethra; second stage
- 53430 – Urethroplasty, reconstruction of female urethra
- 53431 Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg. Tenago, Leadbetter procedure)
- 54120 – Amputation of penis; partial
- 54125 – Amputation of penis; complete
- 54130 Amputation of penis, radical; with bilateral inguino-femoral lymphadenectomy
- 54135 Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
- 54400 - 54417 Penile prosthesis
- 54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
- 54660 Insertion of testicular prosthesis (separate procedure)
- 54690 Laparoscopic, surgical; orchiectomy
- 55150 Resection of scrotum.
- 55175 Scrotoplasty; simple
- 55180 complicated
- 55899 Phalloplasty
- 55970 Intersex surgery; male to female [a series of staged procedures that includes male genitalia removal, penile dissection, urethral transposition, creation of vagina and labia with stent placement]
- 55980 female to male [a series of staged procedures that include penis and scrotum formation by graft, and prostheses placement]
- 56620 Vulvectomy simple; partial.
- 56625 Vulvectomy simple; complete
- 56800 Plastic repair of introitus
- 56805 Clitoroplasty for intersex state
- 56810 Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
- 57106 - 57107, 57110 - 57111 Vaginectomy
- 57291 - 57292 Construction of artificial vagina
- 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
- 57530 Trachelectomy (cervicectomy), amputation of cervix (separate procedure).
- 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;
- 58262 Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
- 58263 Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele.
- 58267 Vaginal hysterectomy, for uterus 250 g or less; with colpourethrocystopexy (Marshall)
- 58270 Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele.
- 58275 Vaginal hysterectomy, with total or partial vaginectomy.
- 58280 Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele.
- 58285 Vaginal hysterectomy, radical (Schauta type operation)
- 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)
- 58292 Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele.

- 58293 Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
- 58294 Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele.
- 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 of adnexal structures (partial or total oophorectomy and/or salpingectomy)
- 58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral
- 58940 – Oophorectomy, partial or total, unilateral or bilateral
- 90832 - 90838 Psychotherapy
- 92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
- 92508 Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals
- C1813 Prosthesis, penile, inflatable
- C2622 Prosthesis, penile, non-inflatable
- J1950 Injection, leuprolide acetate (for depot suspension), per 3.75 mg
- J9217 Leuprolide acetate (for depot suspension), 7.5 mg
- J9218 Leuprolide acetate, per 1 mg
- J9219 Leuprolide acetate implant, 65 mg

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

#### **LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

#### **REFERENCES:**

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Oles N, Darrach H, Landford W, et al. Gender affirming surgery: A comprehensive, systematic review of all peer-reviewed literature and methods of assessing patient-centered outcomes (Part 2: Genital reconstruction). *Ann Surg.* 2022;275(1):e67-e74.

This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 7/16

**Revised:** 9/20 (clarification of exclusion); 9/21 (add exclusion), 9/22 (revise BH professional , add exclusions)

**Reviewed:** 9/17, 9/18, 9/19,

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

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