Clinical Review Criteria Related to Gender Reassignment Surgery

Definition: Transgender is an umbrella term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth (National Center for Transgender Equality, 2009). The term gender reassignment surgery or sexual reassignment surgery (SRS) includes the surgical procedures by which the physical appearance and function of a person's existing sexual characteristics are changed to those of the other sex in an effort to resolve or minimize Gender Dysphoria and improve quality of life. Gender reassignment surgery is part of a treatment plan for gender identity dysphoria.

Gender dysphoria (GD) is defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and the person's assigned sex at birth (World Professional Association for Transgender Health [WPATH], 2011).

I. Gender Reassignment Surgery (GRS) may be considered medically necessary when the following criteria are met:

A. The member is at least 18 years of age and

1. The member has been diagnosed with Gender Identity disorder, and

2. The new gender identity has been present for at least twenty four months, and

3. The member has undergone a minimum of twelve months of continuous hormonal therapy under the supervision of a physician and the physician reports medication compliance. There is no hormonal therapy requirement for mastectomy only.

4. If the member has a significant mental health issue such as impaired reality testing, bipolar disorder, dissociative disorder and borderline personality disorder, an effort must be made to improve the condition with psychotropic medications and/or psychotherapy before surgery is contemplated.

II. Required Documentation:

A. A letter of medical necessity from the members medical and behavioral health providers who have had an evaluative role with the member and has been treating the member for a minimum of 12 months. The letter must include the following:

1. General identifying characteristics

2. Initial and evolving gender, sexual and other psychiatric diagnoses

HNE Review Dates: 11/11/14, 5/12/15, 11/10/15, 9/13/16, 11/8/16
MHI Review Dates: 1/1/2014, 10/23/2014, 07/02/2015, 2/2/2016, 10/20/2016, 02/09/2017

3. Compliance with prescribed treatments and likelihood of future compliance

4. Participation in psychotherapy throughout the twelve months of member's experience in the identified gender role.

5. Confirmation that the member has completed twelve months of continuous, full time life experience living in a gender role that is congruent with member's gender identity. This process assists in confirming the member's ability to function in this role long-term, as well as the adequacy of his/her support system. During this time period, the member would be expected to maintain their baseline functional lifestyle with work or school and participate in community activities.

B. A letter from the treating surgeon attesting that the member meets criteria outlined in this policy. The surgeon should have a demonstrated competency and extensive training in sexual reconstructive surgery.

1. The surgeon believes the member is likely to benefit from surgery.

2. The surgeon has communicated with the treating physician and the treating behavioral health provider.

3. The surgeon has communicated with the member and that the member understands
   a. The required length of hospitalization (s)
   b. Possible complications
   c. Post-surgical rehabilitation requirements

III. Covered Procedures:

CPT®* Codes	**Description**
55970†	Intersex surgery; male to female
† Includes only the following procedures:	
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state

CPT®* Codes	Description
55980†	Intersex surgery, female to male
† Includes only the following procedures:	
19303	Mastectomy, simple, complete

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19304	Mastectomy, subcutaneous
53430	Urethroplasty, reconstruction of female urethra
56625	Vulvectomy simple; complete
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);
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; 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)
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)
54660	Insertion of testicular prosthesis
55180	Scrotoplasty complicated
55175	Repair of Scrotum
89259	Cryopreservation; sperm
89337	Cyropreservation; mature oocyte(s)
89343	Storage, (per year); sperm/semen
89346	Storage, (per year); oocyte(s)

A. Cryopreservation of eggs or sperm (including retrieval and up to one year of storage) will be covered for members undergoing gender reassignment treatment when documentation confirms a member with GD will be undergoing this treatment which is likely to result in infertility. Minuteman Health Insurance, however, does not cover any costs associated with any form of Surrogacy including gestational carriers.

B. Benefits are limited to one gender affirming surgery per lifetime, which may include several staged procedures.

IV. What is not Covered:

A. Cosmetic procedures to enhance physical appearance:

1. abdominoplasty
2. blepharoplasty
3. breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast
4. brow lift
5. calf implants
6. cheek/malar implants
7. chin/nose implants
8. collagen injections
9. electrolysis
10. face/forehead lift
11. hair removal/hair transplantation
12. jaw shortening/sculpturing/facial bone reduction
13. laryngoplasty
14. lip reduction/enhancement
15. liposuction
16. mastopexy
17. nipple/areola reconstruction
18. pectoral implants
19. removal of redundant skin
20. replacement of tissue expander with permanent prosthesis testicular insertion
21. rhinoplasty
22. skin resurfacing (e.g., dermabrasion, chemical peels)
23. trachea shave/reduction thyroid chondroplasty
24. voice modification surgery
25. voice therapy/voice lessons

References:

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Summary of Changes:
02/09/2017

- II., Required Documentation: Deleted all of paragraph A.

Made paragraph B paragraph A. In this paragraph, deleted the words "second," "should be," "a provider," and "has."

From: A second letter of medical necessity should be from a provider who has had an evaluative role with the member and has been treating the member for a minimum of 12 months. The letter must include the following:
To:
A letter of medical necessity from the member's medical and behavioral health providers who have had an evaluative role with the member and have been treating the member for a minimum of 12 months. The letter must include the following:

(Paragraph C. is now paragraph B.)