Gender Confirming Surgery

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Important Information - Please Read Before Using This Policy

UCare has developed medical policies to assist in the determination of coverage of a clinical service (such as a procedure, therapy, diagnostic test, medical device, etc.), when coverage requires determination of medical necessity. Clinical services referenced in UCare's medical policies may not be covered by every UCare plan. Coverage is determined by federal and state regulation and by Patient contract materials, such as the Evidence of Coverage (EOC), Patient Contract, or Patient Handbook. This medical policy alone does not guarantee coverage.

Coverage is subject to the benefits or restrictions of the Patient's specific plan, which will supersede this medical policy when applicable. Please refer to the end of this document to read "How Coverage Is Determined in Specific UCare Plans."

UCare's medical policies are periodically reviewed and updated using published clinical evidence. In addition to medical policies, UCare uses tools for determination of medical necessity that are developed by external sources, including but not limited to McKesson InterQual Criteria and Hayes Inc. Knowledge Center. This medical policy does not constitute the practice of medicine or medical advice. Treating health care providers are solely responsible for determining what care to provide to patients. Patients should always consult their provider before making any decisions about medical care.

Administrative Procedure

Prior authorization IS required for gender confirming surgery.
CPT® codes are listed below in the codes section.

UCare prior authorization form is available here:
https://www.UCare.org/providers/Eligibility-Authorizations/Pages/EligibilityAuth.aspx

Definitions and Scope of this Policy

Medical and surgical treatments of gender dysphoria in transgender individuals involves, psychotherapy, hormonal therapy and, in some cases, gender affirmation surgery.

Female-To-Male (FTM): females transitioning to males.

Male-To-Female (MTF): Males transitioning to female.

Gender Dysphoria: a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. (DSM 5 criteria).

Gender Reassignment: refers to the hormonal and surgical reassignment of gender dysphoric persons.

Gender Reassignment Surgery: may involve any of a number of procedures including mastectomy, reduction mammoplasty, orchiectomy, penectomy, urethroplasty, vaginoplasty, labiaplasty, clitoroplasty, hysterectomy, salpingectomy, oophorectomy, vaginectomy and phalloplasty or metoidioplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis. Also, genital electrolysis is not considered a surgical procedure, but is often performed in conjunction with genital surgery.

Hormonal Gender Reassignment: refers to the administration of androgens (male hormones) to genetic females and estrogens and/or progesterones (female hormones) to genetic males for the purpose of effecting somatic changes (softening of skin, hair growth, breast development etc.) in order to more closely approximate the physical appearance of the other gender.

Primary Sex Characteristics refer to the genetically determined sex characteristics related to reproduction. The primary sex characteristics are the genital organs and their related hormones.

Secondary Sex Characteristics refer to various genetically transmitted physical or behavioral characteristics that appear in humans at puberty and differentiate between the sexes without having a direct reproductive function.

Medical Necessity Criteria

Treatment for gender dysphoria does not consist of a single procedure, but is part of a process

involving multiple medical and surgical modalities.

Gender-confirming surgery (GCS) is considered medically necessary when a person has been diagnosed as having gender dysphoria and meets **ALL** of the criteria.

- Patient is 18 years of age or older, AND
- Documentation supporting that the patient has lived in the gender role that is congruent with their gender identity for at least 12 continuous months, AND
- For chest surgery, a written referral from one clinician with expertise in transgender health and who has an established and ongoing relationship with the patient, AND
- For genital surgery, a written referral from two independent clinicians with expertise in transgender health, at least one of whom has an established and ongoing relationship with the patient, AND
- Written referrals from clinicians qualified in the behavioral aspects of gender dysphoria. Behavioral health professionals, the patient's treating provider (physician, nurse practitioner, P.A., clinical nurse specialist), or both.
- The referral letters must meet the following requirements:
    - A referral letter from a behavioral health provider must include a recent diagnostic assessment.
    - In the absence of a diagnostic assessment, the patient's medical provider (physician, PA, nurse practitioner or clinical nurse specialist) must complete a psychosocial assessment. Including ALL of these components.
        - ✓ Patient's current life situation
        - ✓ Current living situation, including household members and housing status
        - ✓ Basic needs status including economic status
        - ✓ Education level and employment status
        - ✓ Significant personal relationships, including the patient's evaluation of relationship quality
        - ✓ Strengths and resources including the extent and quality of social networks
        - ✓ General physical health
        - ✓ Current medications
        - ✓ Description of symptoms
        - ✓ Perception of his or her condition
        - ✓ History of mental health treatment, including review of records
        - ✓ Developmental incidents
        - ✓ Maltreatment or abuse
        - ✓ History of alcohol or drug abuse
        - ✓ Personal and family health history
        - ✓ Cultural influences and impact on diagnosis and possibly on treatment

- ✓ Mental status exam and clinical summary
- ✓ Assessment of the patient's need based on baseline measurements, symptoms, behaviors, skills, abilities, resources, vulnerabilities and safety needs
- ✓ Screening used to determine substance abuse and other standardized screening instruments (CAGE-AID, GAIN-SS)
- ✓ Prioritization of needed mental health, ancillary or other services
- ✓ Patient and family participation in assessment
- ✓ Referrals to services and service preferences by individual
- ✓ How the criteria for a diagnosis of gender dysphoria is met: symptoms, duration and functional impairment
- ✓ Strengths, cultural influences, life situations, relationships, health concerns and how gender dysphoria diagnosis interacts with or impacts patient's life
- ✓ Primary diagnosis of gender dysphoria. If any other mental health or substance use disorders are present, make a referral to a mental health professional or a substance use treatment specialist

In addition to a diagnostic or psychosocial assessment, the referral letter must include the clinician's attestation about **each** of the following:

- The patient's general identifying characteristics
- The duration of the referring provider's relationship with the patient, including the type of evaluation and therapy or counseling that the patient underwent
- An explanation that the patient has met criteria for surgery and a brief description of the clinical rationale for supporting the request for surgery
- A statement that the clinician obtained informed consent
- A statement that the treating provider is available for coordination of care
- Affirmation of gender dysphoria diagnosis
- If significant medical or mental health concerns are present, documentation must support that these concerns are reasonably well controlled in addition to the patient's adherence to recommended medical and behavioral treatment plans. This includes the following:
  - ✓ Twelve months of continuous hormone therapy for genital surgery or twenty-four months of continuous hormone therapy for breast augmentation
  - ✓ Behavioral health therapy: patient is receiving treatment, is in recovery, or is in stable remission of any co-morbid behavioral health conditions that are not attributed to dysphoria (for example, psychosis, trauma, substance use disorder) for 12 continuous months. Stable remission is defined as lack of hospitalization, day treatment or emergent care for any co-morbid behavioral health conditions during the 12-month period before surgery
  - ✓ No medical contraindications for surgery

COVERED SERVICES

UCare covers the following Gender Confirming Surgery:

- Hysterectomy and salpingo-oophorectomy
- Vaginectomy (including colpectomy, metoidioplasty, phalloplasty, urethoplasty, urethromeatoplasty
- Mastectomy, breast reduction, chest reconstruction
- Penile prosthesis (noninflatable or inflatable)
- Orchiectomy
- Vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy)

In addition to these specific covered procedures, the following procedures may also be covered when medically necessary:

- Breast augmentation surgery for male-to-female GCS when the patient exhibits no response after being adherent to hormone therapy for at least 24 months (unless contraindicated) and gender dysphoric symptoms remain after hormone treatment
- Scrotoplasty, testicular expanders, and testicular prostheses for female-to-male GCS

NONCOVERED SERVICES

When part of Gender Confirming surgery the following procedures are considered cosmetic and not medically necessary; therefore, these services are excluded from UCare coverage:

- Abdominoplasty
- Blepharoplasty
- Brow lift
- Calf implants
- Cheek or malar implants
- Collagen injections
- Electrolysis or laser hair removal unless other hair removal techniques on the site after surgery would be unsafe
- Face or forehead lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair transplantation
- Jaw reduction
- Laryngoplasty
- Lip reduction or enhancement

- Lipofilling or collagen injections
- Liposuction
- Mastopexy
- Neck tightening
- Nose implants
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing (dermabrasion, chemical peels)
- Trachea shave or thyroid cartilage reduction (chondroplasty)
- Voice modification surgery
- Voice therapy or voice lessons

Applicable Codes

The Current Procedural Terminology (CPT®) codes and HCPCS codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other medical policies and coverage determination guidelines may apply.

CPT® Code Ranges Applicable To This Policy

11920 11921 11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 cm^2 or less [when specified for nipple/areola reconstruction after breast surgery; includes codes 11920, 11921, 11922]
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
15775	Punch graft for hair transplant; 1-15 punch grafts.
15776	Punch graft for hair transplant; more than 15 punch grafts
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
17380	Electrolysis epilation, each 30 minutes

17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue [when specified as permanent hair removal by laser]
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19316	Mastopexy
19318	Reduction mammoplasty
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; minor revision (small amount of nasal tip work); intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; minor revision (small amount of nasal tip work); major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture
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 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
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55899	Phallic reconstruction/Phalloplasty (Unlisted procedure, male genital system)

55970	Intersex surgery; male to female
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 - the physician uses various plastic surgery techniques to correct a small, underdeveloped vagina due to the overproduction of male hormones
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach 58150Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
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)
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
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 250g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s
HCPCS	
C1813	Prosthesis, penile, inflatable
L8039	Breast prosthesis, not otherwise specified
L8600	Implantable breast prosthesis, silicone or equal

ICD-10 Procedure	
0HBV0ZZ-0HBVXZZ	Excision of breast, bilateral [by approach; includes codes 0HBV0ZZ, 0HBV3ZZ, 0HBV7ZZ, 0HBV8ZZ, 0HBVXZZ]
0HDSXZZ	Extraction of hair, external approach
0HRW07Z-0HRXXKZ	Replacement of nipple [by approach; includes codes 0HRW07Z, 0HRW0JZ, 0HRW0KZ, 0HRW3JZ, 0HRW3KZ, 0HRW37Z, 0HRWX7Z, 0HRWXJZ, 0HRWXKZ, 0HRX07Z, 0HRX0JZ, 0HRX0KZ, 0HRX3JZ, 0HRX3KZ, 0HRX37Z, 0HRXX7Z, 0HRXXJZ, 0HRXXKZ]
0UQG0ZZ	Repair vagina, open approach
0UQJ0ZZ-0UQJXZZ	Repair clitoris [by approach; includes codes 0UQJ0ZZ, 0UQJXZZ]
0UT20ZZ-0UT2FZZ	Resection of bilateral ovaries [by approach; includes codes 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ]
0UT70ZZ-0UT7FZZ	Resection of bilateral fallopian tubes [by approach; includes codes 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ]
0UT90ZZ-0UT9FZZ	Resection of uterus [by approach; includes codes 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ]
0UTC0ZZ-0UTC8ZZ	Resection of cervix [by approach; includes codes 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ]
0UTG0ZZ-0UTG8ZZ	Resection of vagina [by approach; includes codes 0UTG0ZZ, 0UTG4ZZ, 0UTG7ZZ, 0UTG8ZZ]
0UTJ0ZZ-0UTJXZZ	Resection of clitoris [by approach; includes codes 0UTJ0ZZ, 0UTJXZZ]

0UTM0ZZ-0UTMXZZ	Resection of vulva [by approach; includes codes 0UTM0ZZ, 0UTMXZZ]
0VRC0JZ	Replacement of bilateral testes with synthetic substitute, open approach
0VTC0ZZ-0VTC4ZZ	Resection of bilateral testes [by approach; includes codes 0VTC0ZZ, 0VTC4ZZ]
0VTS0ZZ-0VTSXZZ	Resection of penis [by approach; includes codes 0VTS0ZZ, 0VTS4ZZ, 0VTSXZZ]
0VUS07Z-0VUSX7Z	Supplement penis with autologous tissue substitute [by approach, includes codes 0VUS07Z, 0VUS47Z, 0VUSX7Z]
0VUS0JZ-0VUSXJZ	Supplement penis with synthetic substitute [by approach; includes codes 0VUS0JZ, 0VUS4JZ, 0VUSXJZ]
0VUS0KZ-0VUSXKZ	Supplement penis with non-autologous tissue substitute [by approach; includes codes 0VUS0KZ, 0VUS4KZ, 0VUSXKZ]
0W4M070	Creation of vagina in male perineum with autologous tissue substitute, open approach
0W4M0J0	Creation of vagina in male perineum with synthetic substitute, open approach
0W4M0K0	Creation of vagina in male perineum with non-autologous tissue substitute, open approach
0W4M0Z0	Creation of vagina in male perineum, open approach
0W4N071	Creation of penis in female perineum with autologous tissue substitute, open approach
0W4N0J1	Creation of penis in female perineum with synthetic substitute, open approach
0W4N0K1	Creation of penis in female perineum with non-autologous tissue substitute, open approach
0W4N0Z1	Creation of penis in female perineum, open approach

How Coverage Is Determined In Specific UCare Plans

- **Commercial: UCare Choices/Fairview UCare Choices***:*
  Coverage is determined by the Member Contract. If there is a conflict between this medical policy and the individual Member Contract, the provisions of the Member Contract will govern.

- **Medicare Advantage: UCare for Seniors (HMO Point-of-Service) and EssentiaCare (Preferred Provider Organization)**
  Coverage is determined by guidance from the Centers for Medicare & Medicaid Services

(CMS) National Coverage Determination (NCD) or applicable CMS Local Coverage Determination (LCD) and the applicable UCare Evidence of Coverage (EOC). This medical policy applies in the absence of CMS guidance and/or EOC language.

- **Medicaid – MinnesotaCare: Prepaid Medical Assistance Program (PMAP), UCare Connect (non-SNP/non-integrated), Minnesota Senior Care Plus (MSC+), and MinnesotaCare**
  Coverage is determined by the applicable Evidence of Coverage (also known as the "Member Handbook") and guidance from the Minnesota Department of Human Services (DHS) Minnesota Health Care Programs (MHCP) Provider Manual. This medical policy applies if DHS coverage criteria are not available.

- **Medicare Advantage – Dual Eligible Special Needs Plan: UCare Connect + Medicare and Minnesota Senior Health Options (MSHO)**
  Medicare coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (*UCare Connect + Medicare*) and guidance from the Centers for Medicare & Medicaid Services (CMS). This medical policy applies in the absence of CMS guidance and/or EOC language.

  Medicaid coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (*UCare Connect + Medicare*), and guidance from the DHS MHCP Provider Manual. This medical policy applies if coverage criteria have not been determined by DHS.

Revision History
5/1/2018