KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Gender Reassignment Surgery

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	MM9981 - Gender Dysphoria and Gender Reassignment Surgery
KPWA Medical Policy	Due to the absence of a NCD, LCD, or other coverage guidance, KPWA has chosen to use their own Clinical Review Criteria, "Gender Reassignment Surgery" for medical necessity determinations. Use the Non-Medicare criteria below.

For Microsoft employees: Please see page 131 of Microsoft contract
For PEBB - Uniform Medical Plan Transgender Services Clinical Criteria and Policy
For Sound Health and Wellness see the Sound Health & Wellness Trust Gender Dysphoria Coverage Policy
For FEHB plans: See the member's contract for specific coverage details
For Washington State Teamsters Trust: See the member's contract for specific coverage details

For Non-Medicare Members:

Members must be enrolled in the KPWA Transgender Services Program to qualify for the transgender benefit.

I. Requirements for facial hair removal

KP Washington will cover facial hair removal for members with documented gender dysphoria and who are transfeminine. The area of treatment is limited to the face and throat and excludes eyebrows. Member can have either electrolysis or laser hair removal or both. The member must work with the KPWA Gender Health Case Manager to determine the best provider for the service and arrange for either insurance billing or member reimbursement for services. The member needs to have active status at the time of the service. Pt needs to be age 18 or older or have parental consent.

Unless there are medical contraindications to therapy, patients should undergo feminizing hormone therapy aimed at decreasing androgen effects prior to hair removal to enhance efficacy and prevent additional/recurrent terminal hair growth. Adequate androgen blockade can be demonstrated by **ONE** of the following:

a. 6 months or longer of medical therapy aimed at decreasing androgen production or effects (for example, spironolactone/ GNRH agonists/ finasteride with or without estrogen) **OR**
b. Serum testosterone (total) in the normal female range (<100mg/dL) OR
c. History of prior gonadectomy

Note: Patients who have not had gender reassignment surgery (gonadectomy or vaginoplasty) should continue hormone/anti-androgen therapy unless contraindicated during and after hair removal to prevent recurrence.

.

II. Requirements for Mastectomy (i.e., initial mastectomy, with nipple sparing or tattooing) for female-to-male patients. Member must meet **ALL of the following**:

Back to Top

A. Age 18 years or older (Note: age requirement will not be applied to mastectomy in Female-to-Male patients if the surgeon, the primary care provider, and the qualified mental health professional unanimously document the medical necessity of earlier intervention)
B. Single letter of referral from a qualified mental health professional*; *and*
C. Persistent, well-documented gender dysphoria per DSM 5 Gender Dysphoria; *and*
D. Capacity to make a fully informed decision and to consent for treatment; *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled. The health plan may require a second opinion regarding the patient's stability prior to surgery if in question.
F. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

- Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy for members. If the referring medical provider or mental health provider requests surgical intervention prior to the patient's completion of 12 months of living in desired gender, the surgeon, the primary care provider, and the qualified mental health professional must submit evidence of medical necessity and clear rationale for the proposed surgical intervention to be done early. The three providers must submit written documentation to the plan that includes:
  a. A comprehensive, coordinated treatment plan with evidence that all treatment plan criteria for surgery and treatment goals have been met; and
  b. Clear rationale for the variation from the 12-month period of living in desired gender; and
  c. Patient understands the treatment plan, risks and benefits of surgery prior to completing the 12-month period; and
  d. The plan will determine authorization and consent to care based on medical necessity from the documentation outlined in A-F above.

III. Requirements for breast augmentation for male-to-female members:
A. Single letter of referral from a qualified mental health professional; and
B. Persistent, well-documented gender dysphoria per DSM 5 Gender Dysphoria; and
C. Capacity to make a fully informed decision and to consent for treatment; and
D. Age 18 years or older (Note: age requirement will not be applied to augmentation in Male-to-Female patients if the surgeon, the primary care provider, and the qualified mental health professional unanimously document the medical necessity of earlier intervention)
E. If significant medical or mental health concerns are present, they must be reasonably well controlled. The health plan may require a second opinion regarding the patient's stability prior to surgery if in question; and
F. Twelve months of living in a gender role that is congruent with their gender identity (real life experience) and
G. Twelve months of continuous hormone therapy as appropriate to the member's gender goals.

If the referring medical provider or mental health provider requests surgical intervention prior to the patient's completion of 12 months of hormone therapy and/or living in desired gender, the surgeon, the primary care provider, and the qualified mental health professional must submit evidence of medical necessity and clear rationale for the proposed surgical intervention to be done early. The three providers must submit written documentation to the plan that includes:
a. A comprehensive, coordinated treatment plan with evidence that all treatment plan criteria for surgery and treatment goals have been met; and
b. Clear rationale for the variation from either the 12-month period of hormone therapy and/or living for 12 months in desired gender; and
c. Patient understands the treatment plan, risks and benefits of surgery prior to completing the 12-month period; and
d. The plan will determine authorization and consent to care based on medical necessity from the documentation outlined in A-G above.

Back to Top

The criteria above apply for only initial male to female augmentation mammaplasty, any additional breast augmentation after an initial mammaplasty is considered a cosmetic procedure, and therefore, a contract exclusion.

IV. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male to-female):
- A. Two referral letters from qualified mental health professionals*, one in a purely evaluative role. (At least one letter should be an extensive report. Two separate letters or one letter with two signatures is acceptable. One referral letter can be from a KPWA Gender Health Case Manager and the other needs to be from a qualified mental health professional*); and
- B. Persistent, well-documented gender dysphoria per DSM 5 Gender Dysphoria; *and*
- C. Capacity to make a fully informed decision and to consent for treatment; *and*
- D. Age of majority (18 years or older); *and*
- E. If significant medical or mental health concerns are present, they must be reasonably well controlled. The health plan may require a second opinion regarding the patient's stability prior to surgery if in question; *and*
- F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones – chart notes must describe the contraindications in detail)

V. Requirements for genital reconstructive surgery (Vaginectomy, colpectomy, metoidioplasty, vaginoplasty, colovaginoplasty, penectomy, clitoroplasty, labioplasty, phalloplasty, scrotoplasty, urethroplasty, testicular prosthesis (expanders and implants), penile prosthesis. M–F hair removal in the pubic surgical area.)
- A. Two referral letters from qualified mental health professionals*, one in a purely evaluative role (At least one letter should be an extensive report. Two separate letters or one letter with two signatures is acceptable. One referral letter can be from a KPWA Gender Health Case Manager and the other needs to be from a qualified mental health professional*); and
- B. Persistent, well-documented gender dysphoria per DSM 5 Gender Dysphoria; and
- C. Capacity to make a fully informed decision and to consent for treatment; and
- D. Age 18 years and older; and
- E. If significant medical or mental health concerns are present, they must be reasonably well controlled. The health plan may require a second opinion regarding the patient's stability prior to surgery if in question; and
- F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); and
- G. Twelve months of living in a gender role that is congruent with their gender identity (real life experience)

EFFECTIVE 02/01/2019

VI. Eligibility for MtF procedure: Layrngochrondroplasty is based on meeting **ALL of the following** criteria:
- A. Member is at least 18 years old
- B. Member has been diagnosed with persistent, well documented gender dysphoria.
- C. Member has the capacity to make fully informed decisions and to consent to treatment.
- D. If significant medical or mental health concerns are present, they are reasonably well controlled.
- E. Member has a current referral for laryngochrondroplasty surgery from a qualified mental health professional who has independently assessed the patient. This assessment must be current within the past 12 months. For providers working within a multidisciplinary specialty team, the assessment and recommendation can be documented in the patient's chart. The referral is expected to cover the following recommended content:
  - a. The client's general identifying characteristics.
  - b. Results of the client's psychosocial assessment, including any diagnoses.
  - c. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date.
  - d. An explanation that the criteria for surgery have been met and a brief description of the clinical rationale for supporting the patient's request for surgery.

 Back to Top

e. A statement about the fact that the patient has the capacity to provide informed consent.
f. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

F. Member has had a mental health evaluation and a medical evaluation, and has been deemed to have no medical or psychological contraindications for surgery.

VII. The following procedures are **not covered** as a part of this benefit:

- Abdominoplasty
- Blepharoplasty
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Cryopreservation of fertilized embryos
- Drugs for hair loss or growth
- Electrolysis, except for facial hair removal and as needed for genitourinary reconstructive surgery
- Face/forehead lift
- Facials
- Facial feminization surgery including but not limited to: facial bone reduction and facial plastic reconstruction
- Hair implant
- Jaw shortening/sculpting/facial bone reduction
- Laryngoplasty
- Lip reduction/enhancement
- Liposuction
- Mastopexy
- Mons Resection (15839)
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Rhinoplasty
- Sperm preservation in advance of hormone treatment or gender surgery
- Travel expenses
- Ultrasonic Assisted Lymphatic Massage
- Voice modification surgery
- All other cosmetic procedures that do not meet medical necessity

* Characteristics of a Qualified Mental Health Professional:

1. Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent; and
2. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; and
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria;
4. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and
5. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, KPWA will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Back to Top

Gender Dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. Gender dysphoria is only experienced by some gender-nonconforming people.

Transgender individuals usually present to the medical profession with a sophisticated understanding of their identity, and a desired course of treatment, including hormone therapy and potentially gender-realignment surgery. The therapeutic approach to gender dysphoria consists of three elements: hormones, real life experience and, finally, surgery for some patients.

The use of hormone therapy and surgery for gender transition/affirmation is based on many years of experience treating transgender people. Research on hormone therapy is providing us with more and more information on the safety and efficacy of hormone therapy, but all of the long-term consequences and effects of hormone therapy may not be fully understood. Therefore, a careful diagnosis, differential diagnosis, and exploration of identity is absolutely vital to the patient's best interest and the patient provider relationship. A vital part of the long-term diagnostic therapy is the so-called real-life experience, in which the patient lives as a member of the desired gender continually and in all social spheres in order to accumulate necessary experience.

Hormone therapy and gender-realignment surgery are superficial changes in comparison to the major psychological adjustments necessary in affirming gender identity. One aspect of treatment should concentrate on the psychological adjustment, with hormone therapy and gender-realignment surgery being viewed as confirmatory procedures dependent on adequate psychological adjustment. Many providers and organizations are moving to an informed consent model for hormones but surgery still needs involvement of psychology and psychiatry. Psychiatric care may need to be continued for many years after gender-realignment surgery. The overall success of treatment depends partly on the technical success of the surgery, but more crucially on the psychological adjustment of the patient, and the support from family, friends, employers and the medical profession.

Evidence and Source Documents

There was no evidence review conducted for these criteria. They were developed in response to the Washington State RCW for the coverage of transgender services.

Date Created	Date Reviewed	Date Last Revised
12/15/2010	01/04/2011 MDCRPC ,11/01/2011 MDCRPC, 09/04/2012 MDCRPC , 07/02/2013 MDCRPC, 05/06/2014 MPC, 11/04/2014MPC, 09/01/2015MPC, 07/05/2016MPC, 03/06/2018MPC	12/04/2018

MDCRPC Medical Director Clinical Review and Policy Committee
MPC Medical Policy Committee

Revision History	Description
11/2/2015	Added Providence Health & Services and link to Sound Health & Wellness Policy & ICD-10 codes
03/08/2016	Added PEBB link
09/02/2016	Added FtM Mastectomy criteria for adolescents 16years and older
11/01/2016	MPC approved revised indication for Electrolysis
10/02/2017	Removed the requirement for testosterone treatment for members 16-18
02/06/2018	Added criteria for M-F breast augmentation
05/01/2018	Added facials and ultrasonic assisted lymphatic massage to the non-covered list
06/05/2018	Changed the mastectomy and breast augmentation criteria
06/11/2018	Added coverage language for facial hair removal
07/10/2018	Added coverage and revised criteria language for facial hair removal
10/02/2018	Updated evaluation criteria under genital reconstructive surgery requirements
12/04/2018	Added MtF criteria to add coverage for Layrngochrondroplasty (Tracheal Shave)

Codes

CPT: Male-Female 55970 Female-Male 55980
ICD-10 F64.1, F64.2, F64.8, F64.9
Electrolysis: 17380

Back to Top