Mass General Brigham
Health Plan

Medical Policy
Gender Affirming Procedures

Policy Number: 024

	Commercial and Qualified Health Plans	MassHealth	Medicare Advantage
Authorization required	X	X	X
No Prior Authorization			
Not covered			

Overview
The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine the medical necessity for gender affirming procedures. This coverage criteria speaks to procedures associated with gender affirmation. The treating specialist must request prior authorization.

Mass General Brigham Health Plan covers medical therapy including gender-affirming hormone therapy and puberty blockers. Authorizations for medications should be submitted through Pharmacy[1].

For MGB ACO Members, Mass General Brigham Health Plan aligns with MassHealth Guidelines for Medical Necessity Determination for Gender Affirming Surgery.

Gender Affirming Covered Procedures
Mass General Brigham Health Plan covers the following Transfeminine procedures:
1. Vaginoplasty
2. Orchiectomy
3. Clitoroplasty
4. Penectomy
5. Labiaplasty
6. Augmentation Mammoplasty/Breast Augmentation
7. Vulvoplasty
8. Urethroplasty

Mass General Brigham Health Plan covers the following Transmasculine procedures:
1. Vaginectomy
2. Vulvectomy
3. Urethroplasty
4. Phalloplasty
5. Metoidioplasty
6. Mastectomy
7. Scrotoplasty with insertion of testicular prosthesis
8. Hysterectomy
9. Erectile and testicular prosthesis
10. Salpingo-oophorectomy

[1]Please refer to plan materials to confirm Pharmacy Benefit coverage is included with your Mass General Brigham Health Plan benefit plan. For those plans that do not include Pharmacy coverage and have a separate Pharmacy Benefit Manager, prescription medication for gender affirmation may be covered under the prescription drug benefit.

Gender Affirming Surgery General Coverage Criteria

Gender-affirming surgeries (including breast/chest, genital, facial, and vocal cord) are considered medically necessary when the Health Plan has received documentation of all of the following:

1. A qualified behavioral health professional has completed a comprehensive psychosocial assessment
2. The duration of the behavioral health professional's relationship with the member, including the type of evaluation and/or psychotherapy that the member received
3. The member has capacity to make fully informed decisions and consent to treatment
4. The member has had gender dysphoria / gender incongruence for at least 6 months
5. The initial and evolving gender
6. Any comorbid psychiatric diagnoses
7. Any significant mental health concerns are well controlled
8. The behavioral health provider's rationale for surgery
9. The physician who is prescribing hormone therapy has consulted with the behavioral health provider as applicable [2]
10. The degree to which the member has followed the treatment requirements to date and the likelihood of future compliance
11. Demonstrable progress on the part of the Member in consolidating the new gender identity, including improvements in:
    a. The ability to function in work, and within family and interpersonal relationships
    b. Behavioral Health issues should they exist
12. A presurgical evaluation has been completed, including the following:
    a. The surgeon has assessed that the member is likely to benefit from surgery
    b. The surgeon has consulted with the treating qualified behavioral health provider(s) and physician treating the member
    c. The surgeon has personally communicated with the member and validates that the member understands the ramifications of surgery, including:
        i. The required length of hospitalization(s)
        ii. The different surgical techniques and advantages and disadvantages of each technique
        iii. Limitations of surgical procedures
        iv. Risks and complications of planned surgical procedures; and
        v. The post-surgical rehabilitation requirements of the planned surgeries

Procedure-Specific Criteria

Chest/Breast Surgeries

For members 18 years or older, Mass General Brigham Health Plan covers bilateral mastectomy, breast augmentation, breast reduction (MassHealth only), chest reconstruction/contouring and nipple/areolar complex reconstruction when the General Coverage Criteria above are met. For transmasculine members, there is no requirement for hormone therapy. Although not required, it is recommended that transfeminine members undergo at least 12 months of feminizing hormone therapy prior to breast augmentation surgery for optimal surgical results.

For transmasculine members under 18 requesting coverage of breast/chest surgeries, a Medical Director will evaluate medical necessity on an individual basis.

Genital Surgeries

For members 18 or older, Mass General Brigham Health Plan covers genital surgeries (listed above) when the General Coverage Criteria above are met.

[2] Mass General Brigham Health Plan does not require hormone therapy for transmasculine chest reconstructive surgery.

In addition, requests for genital surgeries require documentation that the member has had 6 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual). The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.

Facial Feminization/Masculinization
Mass General Brigham Health Plan covers facial feminization or masculinization when all of the following requirements are met:

1. The member is at least 18 years of age.
2. The member has been diagnosed with gender dysphoria / gender incongruence meeting DSM-V criteria by a qualified behavioral health professional and has had this condition for at least 6 months.
3. Recommendation for the requested procedure is made by the qualified behavioral health professional mentioned above.
4. Co-morbid medical or behavioral health disorders are appropriately managed, reasonably controlled, and not causing symptoms of dysphoria.
5. The member has capacity to make fully informed decisions and has consented to the procedure after limitations, risks, and complications of the procedure have been discussed.

Covered procedures when medical necessity criteria above are met:

a. Forehead contouring (Osteoplasty)
b. Rhinoplasty/Septoplasty
c. Mandible/jaw contouring- reconstruction
d. Trachea shave or tracheoplasty
e. Blepharoplasty (only as needed in conjunction with other facial feminization procedures)
f. Brow lift
g. Cheek augmentation
h. Rhytidectomy (Face lift) of forehead and cheek, excluding neck. Rhytidectomy is excluded for MassHealth members.
i. Genioplasty
j. Scalp (hairline) advancement
k. Lateral canthopexy
l. Lip lift
m. Lysis intranasal synechia
n. Suction-assisted lipectomy /liposuction (only as needed in conjunction with one of the above procedures).

Surgical Revisions
Mass General Brigham Health Plan covers reconstructive surgery following gender affirmation procedures (including facial feminization/masculinization) only in the following conditions:

1. To correct complications resulting from the initial surgery, OR
2. To correct functional impairment resulting from initial surgery

Hair Removal by Electrolysis or Laser
Mass General Brigham Health Plan covers hair removal with laser or electrolysis, by a board-certified dermatologist or licensed provider for removal of hair on skin being used for genital surgery.

Documentation is required of the plan and timeline for surgery pending completion of hair removal. Up to 12 electrolysis and/or laser hair treatments will be covered if criteria above are met. Prior authorization is required for greater than 12 electrolysis and/or laser hair removal treatments and should include a subsequent letter of medical necessity.

Electrolysis/laser hair removal for any other part of the body is considered cosmetic and not covered for commercial and QHP members.

MASS HEALTH ONLY: Hair removal (including laser hair removal and electrolysis) of the face and neck as part of treatment for gender dysphoria / gender incongruence may be considered medically necessary when all of the following criteria listed below are met and documented.

1. The member has been diagnosed with gender dysphoria / gender incongruence meeting DSM-V criteria by a qualified behavioral health professional and has had this condition for at least 6 months.
2. A licensed qualified health professional recommends hair removal for the member.
3. A letter from the clinician performing the hair removal which includes attestation of the medical necessity of hair removal and a summary of the member's care as it relates to gender dysphoria / gender incongruence treatment.
4. The hair removal must be restricted to the neck and face.
5. The member is 18 years of age or older.
6. Co-occurring medical or behavioral health disorders are appropriately managed and reasonably controlled.
7. The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals unless hormone therapy is medically contraindicated.

Fertility Services (Commercial members only)
Mass General Brigham Health Plan covers services related to fertility preservation in members undergoing gender affirming procedures including oocyte, embryo, or sperm retrieval, freezing and storage for up to 2 years for trans members undergoing hormonal therapy or genital affirmation surgery. Please refer to details of coverage in Mass General Brigham Health Plan's *Assisted Reproductive Services/Infertility Services* medical policy.

Speech Therapy / Vocal Cord Surgery
Mass General Brigham Health Plan will cover speech therapy to treat a communication disorder related to a gender dysphoria / gender incongruence diagnosis. Mass General Brigham Health Plan will cover Wendler Glottoplasty vocal cord surgery for transfeminine members when the requirements noted in the General Coverage Criteria section are met. It is recommended that members consult with a voice and communication specialist both prior to surgery (to ensure preparation of the vocal mechanism for the surgical intervention) and post-surgery to support a return to functional voice production.

Exclusions
Mass General Brigham Health Plan does not provide coverage for:

1. Gender affirming procedures for conditions that do not meet the criteria noted above.
2. Reversal of any surgical procedures related to Gender dysphoria / gender incongruence that do not meet the criteria noted above.
3. When there are contraindications to the planned surgery.
4. Breast surgeries when either the coverage criteria above or criteria in the Breast Surgeries Medical Policy are not met.
5. Cosmetic procedures when either the coverage criteria above or criteria in the Reconstructive and Cosmetic Procedures Clinical Criteria are not met; (unless specified in the Member Handbook or Amendment).
6. Hair transplant (unless specified in the Member Handbook or Amendment)
7. Collagen injections
8. Implants; calf, gluteal or pectoral
9. Lip reduction or enhancement

10. Isolated blepharoplasty
11. Dermabrasion
12. Chemical peels
13. Neck Lift

Medicare Variation

Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan's medical policies are used for coverage determinations. At the time of Mass General Brigham Health Plan's most recent policy review NCD 140.9 states CMS has determined that no NCD is appropriate at this time for gender affirmation surgery for Medicare beneficiaries with gender dysphoria / gender incongruence.

Definitions

Gender Affirming Surgery: A treatment option for people with gender dysphoria / gender incongruence. Gender affirming surgery is not a single procedure but can entail one or multiple procedures as outlined above, typically in conjunction with medical and psychiatric care as clinically relevant, to allow a person to achieve successful behavioral and medical outcomes.

Gender Identity and Gender:

Chapter 199 of the Acts of 2011. Section 7 of chapter 4 of the Massachusetts General Laws, as appearing in the 2010 Official Edition, is:

"Gender identity" shall mean a person's gender-related identity, appearance, or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person's physiology or assigned sex at birth. Gender-related identity may be shown by providing evidence including, but not limited to, medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the gender-related identity or any other evidence that the gender-related identity is sincerely held as part of a person's core identity; provided, however, that gender-related identity shall not be asserted for any improper purpose.

The *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* defines gender dysphoria / gender incongruence as the presence of:

"a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning."

Qualified Behavioral Health Provider: A behavioral health provider with the following qualifications:

1. 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 behavioral health provider should have documented credentials from a relevant licensing board or equivalent for that country.
2. Competence in using the *Diagnostic and Statistical Manual of Mental Disorders* and/or the International Classification of Disease for diagnostic purposes.
3. Ability to recognize and diagnose co-existing behavioral health concerns and to distinguish these from gender dysphoria / gender incongruence.
4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria / gender incongruence.
6. Continuing education in the assessment and treatment of gender dysphoria / gender incongruence. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a behavioral health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria / gender incongruence.

Presurgical Behavioral Health Evaluation: The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria / gender incongruence, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on behavioral health, and the availability of support from family, friends, and peers (for example, in-person or online contact with other transsexual, transgender, or gender-nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria / gender incongruence, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role of behavioral health professionals includes making reasonably sure that the gender dysphoria / gender incongruence is not secondary to, or better accounted for, by other diagnoses.

Related Policies

- Breast Surgeries Medical Policy
- Reconstructive and Cosmetic Procedures Medical Policy
- Assisted Reproductive Services/Infertility Services

Codes

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

This list of codes applies to commercial and MassHealth plans only.

Authorized CPT/HCPCS Codes	Code Description
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; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
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; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
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 (Not covered for MassHealth plans)
15826	Rhytidectomy; glabellar frown lines (Not covered for MassHealth plans)

15828	Rhytidectomy; cheek, chin, and neck (Not covered for MassHealth plans)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
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; orchiectomy
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
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)
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)
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
58999	Unlisted procedure, female genital system (non-obstetrical)
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., 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
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)

21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)

21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21270	Malar augmentation, prosthetic material
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)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum and osteotomies
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
54660	Insertion of testicular prosthesis (separate procedure)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach

67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs)
67950	Canthoplasty (reconstruction of canthus)
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin
69300	Otoplasty, protruding ear, with or without size reduction
31599	Unlisted procedure, larynx (Tracheal Shaving)

Effective

March 2024: Annual Review. Clarified documentation requirements and removed requirement for separate letter of medical necessity from surgeon. Made other minor clarifying edits.
April 2023: Annual review.

1. Medicare Advantage added to table.
2. Term gender incongruence added throughout policy.
3. On page 3, under Chest/Breast surgeries, added statement “will be reviewed by a Medical Director for individual consideration”.
4. On page 3 under Genital Surgery, removed requirement that second health care provider submit documentation. Also changed continuous months of hormone therapy requirement to 6 months.
5. On page 4, added vocal cord surgery.
6. On Page 5, Medicare Variation language added.
7. On Page 5, Gender Affirming Surgery definition revised for clarity.
8. On page 5, removed vocal cord surgery from exclusion list.
9. References updated.

April 2022: Annual review.

1. On Page 2. Clarified language under Gender Affirming Surgery General Coverage Criteria, 1. b, to read “The member has been diagnosed with gender dysphoria / gender incongruence meeting DSM-V criteria by a qualified behavioral health professional and has had this condition for at least 6 months”. Revised 2. c. to include language “the duration of this condition”.
2. On page 3 under Genital Surgeries added language stating, “who could be the member’s primary care provider, other treating healthcare provider, or another behavioral health provider”.
3. On page 4 clarified language under Hair Removal by Electrolysis or Laser section.
4. Changed “mental health” to behavioral health” throughout policy.

February 2022: Off-cycle Review. Revised language under Genital Surgeries section to clarify that another licensed health care provider familiar with the member's health conditions is required. Under Facial Feminization/Masculinization section, edited #h Rhytidectomy language. Updated codes.
October 2021: Off-Cycle Review based on revised MassHealth Guidelines. Policy edited accordingly.

1. On page 1, revised #7 to add verbiage "with insertion of testicular prosthesis"
2. On page 2, revised 1.b. to add verbiage "for at least 6 months"
3. On page 3, Under Chest Breast Surgeries added the following words to the first sentence:
   I. "bilateral" mastectomy
   II. "breast reduction (MassHealth only)"
   III. "chest reconstruction/contouring"
4. On page 4, under "Covered Procedures", edited the following:
   I. Item b added "Septoplasty"
   II. Revised item h to read "Face lift or rhytidectomy; forehead and cheek, excluding neck (excluded for MassHealth)
   III. Added items i. through n.
5. On pages 4 and 5, added MassHealth only for hair removal of face and neck criteria.
6. On page 5; added Speech Therapy Criteria
7. On page 5; added exclusions 8-14.

May 2021: Annual review. The following changes were made:

1. On page 1, added:
   I. "Transfeminine" to sentence under Gender Affirming Covered Procedures heading
   II. "Transmasculine" to sentence under Gender Affirming Covered Procedures heading
   III. "Urethroplasty" under Transmasculine procedures
   IV. "Vulvectomy" under Transmasculine procedures
2. On page 1, removed:
   I. "facial feminization" under Transfeminine procedures
   II. "facial masculinization" under Transmasculine procedures
3. On page 2 changed heading to "Gender Affirming Surgery General Coverage Criteria"
4. On page 3, added:
   I. Subheading "Procedure-Specific Criteria"
   II. Chest/Breast Surgeries section
   III. Genital Surgeries section
   IV. "meeting DSM-V criteria by a qualified mental health professional and the diagnosis has been present for at least 6 months" in item 2b of Facial Feminization/Masculinization Section
5. On page 3, removed:
   I. "Vaginoplasty, Metoidioplasty, Phalloplasty" section
   II. "Adolescent Members" section
6. On page 3, combined the MassHealth and Commercial Facial Feminization/ Masculinization criteria into one section. Removed the requirement that the member complete a minimum of 12 months of successful continuous full-time real-life experience in their new gender. Edited item h and added genioplasty.
7. On page 4, under Hair Removal by Electrolysis or Laser section, added sentence "Reimbursement for up to 12 electrolysis and/or laser hair treatments will be approved if criteria above are met. Prior authorization is required for greater than 12 electrolysis and/or laser hair removal treatments and should include a subsequent letter of medical necessity."
8. On page 4 under Fertility Services section added language "including oocyte, embryo or sperm retrieval, freezing and storage for up to 2 years for trans members undergoing hormonal therapy or genital affirmation surgery"

9. On page 5 under Exclusions, deleted exclusion for voice modification training/ speech therapy.
10. Updated references.

June 2020: Annual review. Revised policy statement on Vaginoplasty, Metoidioplasty, Phalloplasty stating documentation that the member has lived as their reassigned gender full-time for 12 months or more. Clarified policy statement under Hair Removal by Electrolysis or Laser to replace treating provider with licensed provider. Updated code list to include 21196. References updated.
September 2019: Added language to exclusions "unless specified in the Member Handbook or Amendment". Removed language "commercial accounts only" throughout document. Added coverage criteria for Facial Feminization/Masculinization for MassHealth members.
June 2019: Annual review. Changed title of policy to Gender Affirming Procedures. Revised overview section to include hormone therapy and MyCare Family language. Under Gender Affirming Surgery section removed requirement that the diagnosis of gender dysphoria / gender incongruence be done by a behavioral health provider. Under Gender Affirming Surgery, removed requirement that the member complete 12-month, real life experience trial. Changed subheading name from Genital Surgery to Vaginoplasty, Metoidioplasty, Phalloplasty. Added documentation requirement of 12 continuous months living in a gender role congruent with their gender identity. Added Adolescent Members section. Added Surgical Revisions section. Revised criteria under Facial Feminization/Masculinization section. Revised Exclusion section.
August 2018: Changed title of policy to Gender Affirming Treatment. Added facial feminization/masculinization criteria for commercial members only. Added Fertility Services section.
April 2018: Added codes.
December 2017: Annual review. Added criteria for hair removal.
June 2017: Removed language requiring member to receive 12 months of behavioral health evaluation.
November 2016: Annual review
November 2015: Annual review without substantial changes in medically necessary indicators. Gender Identity and Gender definition added.
October 2014: Effective date.

References

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