MEDICAL POLICY

POLICY TITLE	GENDER AFFIRMING SURGERY
POLICY NUMBER	MP-1.144

Effective Date:	5/1/2023

I. POLICY

Gender affirming surgery may be considered **medically necessary** when **all** of the following pre-procedure criteria are met:

- The individual is 18 years of age or older.
  - Individual consideration may be given to those under 18 years old wishing to undergo female to male chest surgery (see additional information in section below‡)
- The individual has been diagnosed with marked and sustained Gender Incongruence or Gender Dysphoria (see Appendix).
- The individual has the capacity to make a fully informed decision and to consent for treatment.
- Documentation of at least 12 months of continuous hormonal therapy as appropriate to the individuals gender goals, (unless medically contraindicated or individual is unable to take hormones)*.
  - It is expected that male to female individuals undergo feminizing hormone therapy for 12 months prior to breast augmentation surgery.
- Recommendation for surgical intervention by one qualified health care professional.
  - A qualified health care professional, for purposes of this policy, is usually a licensed behavioral health care professional. Other health care professionals who can document achievement of WPATH competencies can be considered (see Appendix); and
  - The recommendation letter should include a comprehensive evaluation/report that documents marked and sustained Gender Incongruence or Gender Dysphoria. (see Appendix)
- The individual has lived with the desired gender or gender diverse role full time for at least twelve months without returning to the original gender†.
  - Gender diverse individuals may choose to not adopt social changes such as change in name, pronouns, or gender expression.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

*__Note__: Hormone therapy is not a prerequisite for reduction mammaplasty in adults. Prior to breast augmentation, the purpose of hormone therapy is to maximize breast growth in order to obtain better surgical (aesthetic) results if surgery is a consideration.

†__Note__: This requirement is only for those undergoing genital reconstruction surgery (i.e. vaginoplasty, phalloplasty, or metoidioplasty). It is not a requirement for breast surgery, hysterectomy, or gonadectomy.

Female to Male or Gender Diverse Transition:

When all of the pre-procedure criteria are met, the following breast and genital surgeries may be considered **medically necessary** for transmen or those that are gender diverse:

- Breast reconstruction (e.g., reduction mammaplasty)‡
- Hysterectomy
- Metoidioplasty
- Penile prosthesis insertion
- Phalloplasty
- Salpingo-oopherectomy
- Scrotoplasty
- Testicular prosthesis implantation
- Urethroplasty
- Vaginectomy
- Vulvectomy, simple, complete

‡ __Note__: Chest surgery in Female to Male individuals could be carried out prior to reaching the legal age of majority, 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.

Male to Female or Gender Diverse Transition:

When all of the pre-procedure criteria are met, the following breast and genital surgeries may be considered **medically necessary** for transwomen or those that are gender diverse:

- Breast augmentation
- Colovaginoplasty
- Clitoroplasty
- Labiaplasty
- Orchiectomy
- Penectomy
- Vulvoplasty
- Vaginoplasty

Non-Covered Services:

The following procedures are typically considered **cosmetic** services and **not medically necessary** to align with one's gender, but may be considered **medically necessary**, in unique or acute cases (this list may not be all-inclusive):

- Abdominoplasty
- Blepharoplasty
- Blepharoptosis
- Breast augmentation for purposes not meeting the above criteria
- Breast reduction, implant, revision/reconstruction for purposes not meeting the above criteria
- Brow lift
- Calf augmentation/implants
- Cheek/malar implants
- Chin augmentation
- Collagen injections
- Cricothyroid approximation
- Dermabrasion/Skin resurfacing
- Facial feminizing/sculpturing (e.g., jaw shortening, forehead reduction)
- Forehead lift
- Gamete preservation in anticipation of future infertility
- Hair removal – Electrolysis or laser hair removal*
- Hair transplantation
- Laryngoplasty
- Lip reduction/enhancement
- Liposuction
- Mastopexy
- Nose implants
- Removal of redundant skin
- Rhinoplasty
- Rhytidectomy
- Scrotoplasty
- Trachea shave/reduction thyroid chondroplasty
- Voice modification surgery
- Voice therapy/voice lessons

***Note**: Hair removal is only considered **medically necessary** for skin graft preparation for genital surgery. Hair removal should not begin until the individual has consulted with the surgical team and a donor site has been chosen.

Gender-reversal surgery post-operatively is considered **not medically necessary** and, therefore, not covered.

Note: Surgical procedures for gender affirmation are considered irreversible procedures.

Cross-reference:

MP 1.002 Augmentation Mammoplasty
MP 1.004 Cosmetic and Reconstructive Surgery
MP 2.345 Subcutaneous Hormone Pellet Implants

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross please see additional information below, and subject to benefit variations as discussed in Section VI below.

FEP PPO: Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:
https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

III. DESCRIPTION/BACKGROUND

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Gender incongruence is defined as a condition in which the gender identity of a person does not align with the gender assigned at birth. Gender dysphoria refers to the psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Though gender dysphoria often begins in childhood, some people may not experience it until after puberty or much later.

The term gender affirming surgery, also known as gender reassignment surgery, may be used to mean either the reconstruction of male or female genitals, specifically, or the reshaping, by any surgical procedure, of a male body into a body with female appearance, or vice versa. Gender affirming surgery is part of a treatment plan for gender dysphoria. The causes of gender dysphoria and the developmental factors associated with them are not well-understood. The individual who is genetically male but whose gender identity is female, and who assumes a female gender presentation and role is known as a transwoman; and the individual who is genetically female but whose gender identity is male, and who assumes a male gender presentation and role is known as a transman. The individual whose gender identity doesn't fit inside traditional male or female categories may be known as gender diverse.

For male to female trans identified individuals selected for surgery, procedures may include genital reconstruction (vaginoplasty, penectomy, orchidectomy, clitoroplasty), breast augmentation and cosmetic surgery (facial reshaping, rhinoplasty, abdominoplasty, laryngeal shaving, vocal cord shortening, hair transplants). For female to male trans identified individuals, surgical procedures may include genital reconstruction (phalloplasty, genitoplasty, hysterectomy, bilateral oophorectomy), reduction mammaplasty, chest wall contouring and cosmetic surgery. For gender diverse individuals, procedures may include any of the previously mentioned surgical procedures.

Gender affirming surgery is intended to be a permanent change, establishing congruency between an individual's gender identity and physical appearance and is not easily reversible. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine and urological examination, and a clinical psychiatric/psychological examination. A patient's self-assessment and desire for sex reassignment cannot be viewed as reliable indicators of gender dysphoria.

The American Medical Association (AMA) and the American Academy of Professional Coders (AAPC) gives guidance on coding reduction mammaplasty for gender affirmation. Per AMA, CPT code 19303 (mastectomy) is to be used for the treatment or prevention of breast cancer. AMA Section Guidelines state "when breast tissue is removed for breast-size reduction and not for treatment or prevention of breast cancer, report 19318 (reduction mammaplasty)". Per AAPC, CPT code 19350 (nipple reconstruction) is cosmetic/not medically necessary for transmasculine gender reassignment. AAPC further states that 19318 includes the extra work that may be necessary to reshape the nipple and create an aesthetically pleasing male chest.

IV. RATIONALE

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Professional Society/Organization

WPATH Guidelines: The World Professional Association for Transgender Health (WPATH) promotes standards of health care for individuals through the articulation of "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" (WPATH, 2012). WPATH recommendations for standards of care are based on scientific evidence and expert consensus and are commonly utilized as guidelines for individuals seeking treatment of gender disorders. In addition to breast surgeries (e.g., augmentation mammaplasty, reduction mammaplasty), according to the guidelines the following genital surgeries are considered procedures that may be performed for the treatment of gender dysphoria:

- Hysterectomy.
- Salpingo-oophorectomy (ovariectomy).
- Vaginectomy (e.g., removal of the vagina).
- Metoidioplasty (e.g., clitoral tissue is released and moved forward to approximate the position of a penis, skin from the labia minora is used to create a penis).
- Urethroplasty.
- Scrotoplasty.
- Insertion of erection and/or testicular prosthesis (e.g., the labia majora is dissected forming cavities allowing for placement of testicular implants.)
- Phalloplasty (e.g., skin tissue graft is used to form a penis, the objective for which is standing micturation, improved sexual sensation, function and/or appearance).
- Penectomy.
- Orchiectomy.
- Vaginoplasty/colovaginoplasty (the objective for which is improved sexual sensation, function and appearance).

- Clitoroplasty.
- Vulvoplasty.
- Colovaginoplasty (penile inversion to create a vagina and clitoris, or creation of a vagina from the sigmoid colon).

Endocrine Society Guidelines: In 2017 the Endocrine Society published a clinical practice guideline for endocrine treatment of transsexual persons (Hembree, et al., 2017). As part of this guideline, the endocrine society recommends that transsexual persons consider gender affirming surgery only after both the clinician responsible for endocrine transition therapy and the mental health professional agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being; that surgery be advised only after completion of at least one year of consistent and compliant hormone treatment, unless hormone thrapy is not desired or medically contraindicated; that the clinician responsible for endocrine treatment and the primary care provider is advised to medically clear the individual for gender affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery; that clinicians are recommended to refer hormone-treated transgender individuals for genital surgery when that individual has had a satisfactory social role change, the individual is satisified about the hormonal effects, and the individual desires definitive surgical changes; that clinicians are suggested to delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country; and that clinicians are suggested to determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual (there is insufficient evidence to recommend a specific age requirement).

Summary
Gender affirming surgical procedures, including pre and post-surgery hormone therapy, for diagnosed cases of gender dysphoria should be recommended only after a comprehensive evaluation by a qualified health care professional. The surgeon should have a demonstrated competency and extensive training in sexual reconstructive surgery. Long-term follow-up is highly recommended for the enduringly successful outcome of surgery.

V. DEFINITIONS TOP

GENDER DIVERSE- Per WPATH, gender diverse individuals have often been neglected and/or marginalized and include nonbinary, eunuch, and intersex individuals.

VI. BENEFIT VARIATIONS TOP

The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code on this policy does not denote coverage, as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Non-covered services:

Procedure Codes:

A9282, G0153, S4025, S4026, S9128, 11920, 11921, 11922, 11950, 11951, 11952, 11954, 13100, 13101, 13102, 15734, 15738, 15750, 15770, 15771, 15772, 15773, 15774, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17340, 17360, 19316, 19328, 19340, 19350, 19380, 19499, 21089, 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21209, 21210, 21215, 21230, 21235, 21244, 21245, 21246, 21247, 21248, 21249, 21255, 21256, 21267, 21268, 21270, 21275, 21740, 21742, 21743, 21899, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 31552, 31554, 31574, 31580, 31584, 31587, 31591, 31592, 31599, 31899, 40799, 58321, 58322, 58974, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67999, 89258, 89259, 92507, 92508, 92522, 92524, 97799

Covered when medically necessary:

Procedure Codes:

C1789, C1813, C2622, L8600, 11970, 14000, 14001, 14021, 14040, 14041, 14060, 15100, 15101, 15574, 15757, 15758, 15839, 17380, 17999*, 19300, 19318, 19325, 19342, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 44145, 44207, 52281, 52285, 52290, 53020, 53405, 53410, 53415, 53420, 53425, 53430, 53431, 53450, 53460, 54120, 54125, 54130, 54135, 54308, 54312, 54316, 54318, 54336, 54400, 54401, 54405, 54406, 54408,

54410, 54411, 54415, 54416, 54417, 54440, 54520, 54640, 54650, 54660, 54690, 54692, 54699, 55150, 55175, 55180, 55899, 55970, 55980, 56625, 56800, 56805, 56810, 57106, 57107, 57109, 57110, 57111, 57291, 57292, 57295, 57296, 57335, 57426, 58150, 58180, 58260, 58262, 58275, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720, 58940, 58999, 64856, 64892, 64893, 64896

*Note: 17999 can be used to code for laser hair removal of the donor site

ICD-10-CM Diagnosis Code	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified

IX. REFERENCES

TOP

1. *American College of Obstetricians and Gynecologists (ACOG). Healthcare for Transgender Individuals. Committee Opinion. Number 512, December 2011. Obstet Gynecol 2011:118:1454-8.*
2. *The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013*
3. *Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in J Clin Endocrinol Metab. 2018 Feb 1;103(2):699] [published correction appears in J Clin Endocrinol Metab. 2018 Jul 1;103(7):2758-2759]. J Clin Endocrinol Metab. 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658.*
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9. *Sutcliffe PA, Dixon S, Akehurst RL, Wilkinson A, Shippam A, White S, Richards R, Caddy CM. Evaluation of surgical procedures for sex reassignment: a systematic review. J Plast Reconstr Aesthet Surg. 2009 Mar; 62(3):294-306; discussion 306-8.*
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12. *Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health. 2022; 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644*
13. *Wernick JA, Busa S, Matouk K, Nicholson J, Janssen A. A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery. Urol Clin North Am. 2019;46(4):475-486. doi:10.1016/j.ucl.2019.07.002*
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X. POLICY HISTORY

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MP-1.144	**6/16/2020 Consensus review.** Policy statement unchanged. Coding, Product Variation, Benefit Variation, and Disclaimer updated. References reviewed.
	12/11/20 Administrative update. Removed deleted code 19324 & 19366
	4/13/2021 Major review. Changed title from Gender Reassignment Surgery for Gender Dysphoria to Gender Affirming Surgery. Deleted all the bullet points for what Gender Dysphoria includes. Added last bullet point to pre-procedure criteria. Added *Note, **Note, †Note, and ‡Note. Changed requirements of a mental health professional. Added section to appendix outlining the credentials. Added vulvoplasty to Male to Female transition. Took out all additional criteria for breast augmentation. Modified cosmetic statement.Under Non-Covered Services, added *Note. Clarified gender reversal surgery. Updated Description/Background and references. Made changes to coding.

	8/17/2021 Deleted code 19303 from policy. Placed 19350 into non-covered table. Will use 19318 for FtM reduction mammaplasty.
	12/5/2022 Minor review. Expansion of diagnoses to include marked and sustained Gender Incongruence. Only one recommendation needed for any type of surgery. Updated policy definition of qualified health care professional. “Nonbinary” language updated to “gender diverse”. Gender diverse individuals allowed same interventions as trans individuals. In Definitions Section, defined gender diverse. Updated coding table, background, rationale, references, and appendix.

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Health care benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

Appendix

DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents:

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

WPATH Competencies for Health Care Professionals Assessing Transgender and Gender Diverse Adults for Gender-Affirming Treatments

1. Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.
3. Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
4. Are able to assess capacity to consent for treatment.
5. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
6. Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.

Format for referral letter from a Qualified Health Care Professional:

1. Client's general identifying characteristics; *and*
2. Results of the client's psychosocial assessment, including any diagnoses; *and*
3. The duration of the health care professional's relationship with the client, including the type of evaluation and therapy or counseling to date; *and*
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the client's request for surgery; *and*
5. A statement about the fact that informed consent has been obtained from the client; *and*
6. A statement that the health care professional is available for coordination of care and welcomes a phone call to establish this.

Note: There is no minimum duration of relationship required with the qualified health care professional. It is the professional's judgment as to the appropriate length of time before a referral letter can appropriately be written. A common period of time is three months, but there is significant variation in both directions.

Note: Evaluation of candidacy for gender affirming surgery by a qualified health care professional is covered under the member's medical benefit, unless the services of a health care professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the member's behavioral health benefit.