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 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 individual’s gender goals, (unless medically contraindicated or individual is unable to take hormones)*.
  - It is expected that male to female patients undergo feminizing hormone therapy for 12 months prior to breast augmentation surgery.
- Recommendation for surgical intervention by two qualified mental health professionals with written documentation submitted to the physician performing genital surgery**.
  - A qualified mental health professional, for purposes of this policy, is one who meets WPATH competencies (see Appendix); and
  - One of these letters should include a comprehensive evaluation/report that details well documented gender dysphoria. (see Appendix)
- The individual has lived with the desired gender or non-binary role full time for at least twelve months without returning to the original gender†.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

*Note: Hormone therapy is not a prerequisite for a mastectomy 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:** Only a single letter of referral from a qualified mental health professional is required for breast surgery (augmentation or mastectomy).

†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 Transition:**

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

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

‡ Note: Per WPATH, chest surgery in Female to Male patients 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 Transition:**

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

- Breast augmentation
- Colovaginoplasty
- Clitoroplasty
- Labiaplasty
- Orchiectomy
- Penectomy
Female or Male to Gender Neutral (Non-binary):

When all of the pre-procedure criteria are met, the following may be considered medically necessary for non-binary individuals:

- Breast reconstruction (e.g., mastectomy)
- New procedures and related codes will be reviewed and considered for medical necessity as they become available.

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
II. PRODUCT VARIATIONS

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

FEP PPO: Refer to the FEP Benefit Brochure for information on gender affirming surgery: https://www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms

III. DESCRIPTION/BACKGROUND

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 (and the associated gender role and/or primary and secondary sex characteristics). 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. 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), mastectomy, chest wall contouring and cosmetic surgery.

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/mastectomy for gender affirmation. Per AMA, CPT code 19303 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 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

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 mammoplasty, mastectomy), 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 2009 the Endocrine Society published a clinical practice guideline for endocrine treatment of transsexual persons (Hembree, et al., 2009). As part of this guideline, the endocrine society recommends that transsexual persons consider gender affirming surgery only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery advisable; that surgery be recommended only after completion of at least one year of consistent and compliant hormone treatment; and that the physician responsible for endocrine treatment medically clear the individual for gender affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery.

**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 mental health 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**

N/A

**VI. BENEFIT VARIATIONS**

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 BlueCross. Members and providers should consult the member’s health benefit plan for information or contact Capital BlueCross for benefit information.

VII. DISCLAIMER

Capital BlueCross’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 BlueCross’ Provider Services or Member Services. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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:

<table>
<thead>
<tr>
<th>CPT Codes®</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9282</td>
<td>Wig, any type, each</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
</tbody>
</table>
MEDICAL POLICY

<table>
<thead>
<tr>
<th>POLICY TITLE</th>
<th>GENDER AFFIRMING SURGERY (FORMERLY REASSIGNMENT SURGERY FOR GENDER DYSPHORIA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY NUMBER</td>
<td>MP-1.144</td>
</tr>
</tbody>
</table>

S4025  Donor services for in vitro fertilization (sperm or embryo), case rate
S4026  Procurement of donor sperm from sperm bank
S9128  Speech therapy, in the home, per diem

Covered when medically necessary:

<table>
<thead>
<tr>
<th>CPT Codes®</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11970, 14000, 14001, 14021, 14040, 14041, 14060, 15100, 15101</td>
<td>19370, 19371, 44145, 44207, 52281, 52285, 52290, 53020, 53405</td>
</tr>
<tr>
<td>15574, 15757, 15758, 15839, 17380, 19360, 19364, 19366, 19367, 19368, 19369</td>
<td>19370, 19371, 44145, 44207, 52281, 52285, 52290, 53020, 53405</td>
</tr>
<tr>
<td>19325, 19342, 19357, 19361, 19364, 19367, 19368, 19369</td>
<td>53410, 53415, 53420, 53425, 53430, 53431, 53450, 53460, 53461</td>
</tr>
<tr>
<td>54125, 54130, 54135, 54308, 54312, 54316, 54318, 54336, 54400</td>
<td>54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417</td>
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<tr>
<td>54440, 54520, 54640, 54650, 54660, 54690, 54692, 54699, 55150</td>
<td>55175, 55180, 55866, 55899, 55970, 55980, 56625, 56800, 56805</td>
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<td>58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554</td>
<td>58570, 58571, 58572, 58573, 58661, 58720, 58940, 58999, 64856</td>
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<tr>
<td>64892, 64893, 64896</td>
<td></td>
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</tbody>
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*Note: 17999 is only used to code for laser hair removal of the donor site

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1789</td>
<td>Prosthesis, breast (implantable)</td>
</tr>
<tr>
<td>C1813</td>
<td>Prosthesis, penile, inflatable</td>
</tr>
<tr>
<td>C2622</td>
<td>Prosthesis, penile, noninflatable</td>
</tr>
<tr>
<td>L8600</td>
<td>Implantable breast prosthesis, silicone or equal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Code*</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>F64.0</td>
<td>Transsexualism</td>
</tr>
<tr>
<td>F64.1</td>
<td>Dual role transvestism</td>
</tr>
<tr>
<td>F64.8</td>
<td>Other gender identity disorders</td>
</tr>
<tr>
<td>F64.9</td>
<td>Gender identity disorder, unspecified</td>
</tr>
</tbody>
</table>
IX. REFERENCES


3. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013


### Policy Title

<table>
<thead>
<tr>
<th><strong>Policy Title</strong></th>
<th><strong>Gender Affirming Surgery (Formerly Reassignment Surgery for Gender Dysphoria)</strong></th>
</tr>
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### Policy Number

<table>
<thead>
<tr>
<th><strong>Policy Number</strong></th>
<th><strong>MP-1.144</strong></th>
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</thead>
</table>

### X. Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAC 9/30/15</td>
<td>New policy which addresses if a benefit, criteria that must be met for gender reassignment surgery to be considered medically necessary. Medicare variation added. Coding reviewed/added.</td>
</tr>
<tr>
<td>CAC 7/26/16</td>
<td>Consensus review. Literature review did not reveal any new information that would alter the current policy position. No change to the policy statements. Coding reviewed; codes unranged.</td>
</tr>
<tr>
<td>11/7/16</td>
<td>Administrative update. Updated with new ICD-10-CM code for transsexualism, F64.0, and removed revised diagnosis code F61.1 which is not specific to dual role transvestism. Variation formatting updated. Benefit references removed.</td>
</tr>
<tr>
<td>1/1/17</td>
<td>Administrative update. Added new codes 31574, 31591; effective 1/1/17.</td>
</tr>
<tr>
<td>CAC 11/29/16</td>
<td>Minor review. Additional breast augmentation criteria added for male to female gender reassignment. Initiation of breast surgery removed from the 2nd bullet of the trans-gender counseling criteria. Breast augmentation added to the list of procedures requiring a total of 12 months continuous hormonal sex reassignment therapy. Breast augmentation not meeting criteria added to Non-Covered Services section. Cross reference section updated. Benefit reference removed. Coding reviewed; added new codes 31574, 31591; effective 1/1/17.</td>
</tr>
</tbody>
</table>

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C/A/7/25/17 Minor review. Per WPATH Standards of Care, added the age of FtM chest surgery may be given individual consideration when criteria is met. Twelve month continuous hormonal sex reassignment therapy requirement added for individuals considering breast surgery unless medically contraindicated. Removed nipple/areola reconstruction from non-covered services. Cross reference section updated. Updated coding.

1/17/18 Admin update. Medicare variations removed from Commercial Policies effective 1/1/18.

3/28/18 Consensus review. No changes to the policy statements. References updated.

6/1/18 Administrative update. CPT code 58940 added to policy.

8/13/18 Administrative update. Title change and policy language change; Gender Identity Disorder verbiage revised to Gender Dysphoria.

2/18/19 Consensus review. No change to the policy statements. References reviewed. FEP variation added.

1/1/20 Administrative update. Removed deleted code 19304.

11/12/2019 Minor review. Added section for Female or Male to Gender Neutral (Non-binary) and added statement “New procedures and related codes will be reviewed and considered for medical necessity as they become available.” Removed requirement for hormone therapy with mastectomy per WPATH guidelines. Effective 5/1/2020.


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. Under Non-Covered Services, added *Note. Clarified gender reversal surgery. Updated Description/Background and references. Made changes to coding. 5/11/2021: Modified cosmetic statement.

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 a Qualified Mental Health Professional**

1. A 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 mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.
3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
6. 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.
Mental health professionals with the competencies described above (hereafter called “a qualified mental health professional”) are best prepared to conduct the assessment of gender dysphoria.

**Format for referral letters from a Qualified Mental Health 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 mental health professional’s relationship with the client, including the type of evaluation and therapy or counseling to date; *and*
4. An explanation that the WPATH criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient’s request for surgery; *and*
5. A statement about the fact that informed consent has been obtained from the patient; *and*
6. A statement that the mental health 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 mental health 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. When two letters are required, the second referral is intended to be an evaluative consultation, not a representation of an ongoing long-term therapeutic relationship. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined above.

**Note:** Evaluation of candidacy for sex reassignment surgery by a qualified mental health professional is covered under the member’s medical benefit, unless the services of a mental health 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.