MEDICAL POLICY

POLICY TITLE	GENDER REASSIGNMENT SURGERY FOR GENDER DYSPHORIA
POLICY NUMBER	MP-1.144

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I. POLICY

Gender reassignment 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 individuals under 18 years old wishing to undergo female to male chest surgery (e.g., mastectomy) after one year of testosterone therapy and when all other criteria are met; **and**
- The individual has been diagnosed with Gender Dysphoria of transsexualism or identifies as non-binary which includes **all** of the following:
  - Desire to live as a member of another sex, usually through body changes by surgery and hormone treatment; **and**
  - The individual's transsexual identity (transman, transwoman, or non-binary) has been present for at least two years; **and**
  - Gender Dysphoria causes significant distress and impairs social, occupational, and other important areas of functioning.
- The individual participates in trans-gender counseling and meets **all** of the following:
  - 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; **and**
  - Initiation of hormone therapy (as required) by a qualified health care professional with supportive documentation provided; **and**
  - Recommendation for surgical intervention by two mental health professionals with written documentation submitted to the physician performing genital surgery.
    - One letter should be from a psychiatrist or Ph.D. clinical psychologist and the second letter from a Master's degree mental health professional, or both letters could be from psychiatrists or Ph.D. clinical psychologists. The mental health provider should have experience working with transgender clients; **and**
    - One of these letters should include a comprehensive evaluation/report that details well documented gender dysphoria. (see Appendix)
  - The individual has the capacity to make a fully informed decision and to consent for treatment.

Male to Female Gender Reassignment*:

When all of the above criteria are met for gender reassignment surgery, the following breast and genital surgeries may be considered medically necessary for transwomen (male to female):

- Breast augmentation when one of following additional criteria is met:
  - failure of breast growth stimulation by estrogen (progression only to a young adolescent stage of development); **or**
  - emergence of serious or intolerable adverse effects during estrogen administration; **or**
  - medical contraindication to use of estrogen; **or**
  - risk-benefit analysis determined that surgery is preferable to estrogen therapy.
- Colovaginoplasty; **and**
- Clitoroplasty; **and**
- Labiaplasty; **and**
- Orchiectomy; **and**
- Penectomy; **and**
- Vaginoplasty.

Female to Male Gender Reassignment*:

When all of the above criteria are met for gender reassignment surgery, the following breast and genital surgeries may be considered medically necessary for transmen (female to male):

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

Female or Male to Gender Neutral (Non-binary)*:

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

***Note:** For individuals considering breast augmentation, hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment therapy is required unless medically contraindicated. An additional 12 months

of hormone therapy is not required for vaginectomy or vaginoplasty procedures if already completed with the first stage of these procedures. 12 months of hormone therapy is not required for mastectomy.

Non-Covered Services:
The following procedures are considered **cosmetic** services and **not medically necessary** when used to improve the gender (this list may not be all-inclusive):

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

*Transman to woman or transwoman to man post-operatively is **not covered.**

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Cross-reference:

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

II. PRODUCT VARIATIONS TOP

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 FEP Benefit Brochure for information on gender reassignment surgery: https://www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms

Electrolysis (hair removal) as part of the preparation for gender reassignment surgery is a covered benefit. Refer to the FEP Blue Cross and Blue Shield Service Benefit Plan Brochure 2019 for this information and for a list of covered procedures.

Note* - The Federal Employee Program (FEP) Service Benefit Plan does not have a medical policy related to these services.

III. DESCRIPTION/BACKGROUND TOP

Gender reassignment therapy is an umbrella term which refers to all medical procedures relating to gender reassignment of both transgender (e.g., internal gender identity is incongruent with genetic sex) and people with disorders of sexual development (DSD) (formerly known as “intersex”). The term "gender reassignment surgery," also known as sexual 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 reassignment 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 reassignment 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.

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 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 genital sex reassignment 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 sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery.

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Summary
Sex reassignment 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 TOP

N/A

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

VII. DISCLAIMER TOP

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 TOP

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:

CPT Codes®								
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	17380	17999	19316	19318
19328	19330	19340	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	21267	21268	21270	21275	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	92523	97799	

HCPCS Code	Description
A9282	Wig, any type, each
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
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:

CPT Codes®								
11970	14000	14001	14021	14040	14041	14060	15100	15101
15574	15757	15758	15839	19300	19303	19324	19325	19342
19350	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
55866	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								

HCPCS Code	Description
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, noninflatable
L8600	Implantable breast prosthesis, silicone or equal
C1789	Prosthesis, breast (implantable)

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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

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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. *Day P. Trans-gender Reassignment Surgery. Tech Brief Series. New Zealand Health Technology Assessment. NZHTA Report February 2002, Volume 1, Number 1. [Website]: http://nzhta.chmeds.ac.nz/publications/trans_gender.pdf Accessed June 16, 2020.*
3. *The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013*
4. *Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2009 Sep; 94(9):3132-54.*
5. *Landen M, Walinder J, Hambert G, Lundstrom B. Factors predictive of regret in sex reassignment. Acta Psychiatr Scand. 1998 Apr; 97(4):284-9.*
6. *Lawrence AA. Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. Arch Sex Behav. 2003 Aug; 32(4):299-315.*
7. *Maharaj NR, Dhai A, Wiersma R, Moodley J. Intersex conditions in children and adolescents: surgical, ethical, and legal considerations. J Pediatr Adolesc Gynecol. 2005 Dec; 18(6):399-402.*
8. *Moore E, Wisniewski A, Dobs A. Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects. J Clin Endocrinol Metab. 2003 Aug; 88(8):3467-73.*
9. *Smith YL, van Goozen SH, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. J Am Acad Child Adolesc Psychiatry. 2001 Apr; 40(4):472-81.*
10. *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.*
11. *Tangpricha V, Safer JD. Transgender men: evaluation and management. In: UpToDate Online Journal [serial online]. Waltham, MA; UpToDate: updated 08/22/18 [Website]: www.uptodate.com Accessed June 16, 2020.*
12. *World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. 7th version. Approved September 14, 2011. [Website]:*

https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf. Accessed June 16, 2020.

13. *National Center for Transgender Equality. Medicare and Transgender People. Updated May 2014. [Website]:* http://transequality.org/sites/default/files/docs/kyr/MedicareAndTransPeople.pdf *Accessed June 16, 2020.*
14. *FEP Blue Cross and Blue Shield Service Benefit Plan Brochure 2019. [Website]: https://www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms Accessed June 16, 2020.*

X. POLICY HISTORY

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MP-1.144	**CAC 9/30/15** 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.
	CAC 7/26/16 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.
	11/7/16 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.
	1/1/17 Administrative update. Added new codes 31574, 31591; effective 1/1/17.
	CAC 11/29/16 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.
	CAC 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.

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	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.
	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

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Appendix

Table 1: 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.

Table 2: Format for referral letters from Qualified 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 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, and can be written by a medical practitioner of sufficient experience with gender dysphoria.

Note: Evaluation of candidacy for sex reassignment surgery by a 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.