MEDICAL POLICY

POLICY TITLE	GENDER AFFIRMING SURGERY
POLICY NUMBER	MP 1.144

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**10/1/2025**

I. POLICY

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

- 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 who holds a postgraduate degree. Other health care professionals who can document achievement of WPATH competencies can be considered; and
    - The recommendation letter should include a comprehensive evaluation/report (comprehensive biopsychosocial assessment for adolescents) that documents all of the following:
        - Marked and sustained gender incongruence or gender dysphoria. (see Appendix); and
        - The individual has the capacity to make a fully informed decision and to consent for treatment; and
        - Other possible causes of apparent gender incongruence have been identified and excluded; and
        - Mental and physical health conditions that could negatively impact the outcome of gender affirming medical treatments are assessed, with risks and benefits discussed.
- Documentation of at least 6 months of continuous hormonal therapy as appropriate to the individual's gender goals, (unless medically contraindicated or hormone therapy is not desired).

- Adolescents must have documentation of 12 months of continuous hormonal therapy as appropriate to the individual's gender goals (unless medically contraindicated or hormone therapy is not desired).

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

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

Other Gender Affirming Interventions:

When all of the pre-procedure criteria are met, the following procedures may be considered **medically necessary** when the intervention is expected to effectively treat the individual's gender incongruence and/or dysphoria (this list may not be all-inclusive):

- Abdominoplasty
- Blepharoplasty
- Blepharoptosis
- 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
- 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: Additional procedures may be available based on an individual's benefit.

Detransition, to include surgical intervention, may be considered **medically necessary** when all of the following criteria have been met:

- The individual is being cared for by a comprehensive multidisciplinary assessment team; and
- Social transition has been discussed and considered; and
- The individual has lived in the social role for a prolonged period of time (if recommended by the multidisciplinary team); and
- The assessing health care professional, who is a member of the comprehensive multidisciplinary assessment team, documents how detransition is in the best interest of the individual.

Cross-References:

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 and subject to benefit variations as discussed in Section VI. Please see additional information 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.

Transgender and gender diverse (TGD) is a broad and comprehensive term that describes members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth.

The goal of gender-affirming care is to partner with TGD people to holistically address their social, mental, and medical health needs and well-being while respectfully affirming their gender identity. Gender-affirming interventions include puberty suppression, hormone therapy, and gender-affirming surgeries among others. It should be emphasized there is no 'one-size-fits-all' approach and TGD people may need to undergo all, some, or none of these interventions to support their gender affirmation.

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. The choice to detransition is proportionally rare.

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)".

IV. RATIONALE

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Professional Society/Organization

World Professional Association for Transgender Health (WPATH) Guidelines: "There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in TGD people in need of these treatments. Gender-affirming interventions may also include hair removal/transplant procedures, voice therapy/surgery, counseling, and other medical procedures required to effectively affirm an individual's gender identity and reduce gender incongruence and dysphoria. Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not

considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria."

V. DEFINITIONS

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ADOLESCENT- Refers to the start of puberty until the legal age of majority.

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

VI. DISCLAIMER

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Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These polices are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

VII. 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.

Covered when medically necessary:

Procedure Codes:

A9282, C1789, C1813, C2622, G0153, L8600, S9128, 11920, 11921, 11922, 11950, 11951, 11952, 11954, 11960, 11970, 11971, 13100, 13101, 13102, 14000, 14001, 14021, 14040, 14041, 14060, 15100, 15101, 15574, 15734, 15738, 15750, 15757, 15758, 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*, 19300, 19316, 19318, 19325, 19328, 19350, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 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, 31591, 31592, 31599, 31899, 40799, 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, 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, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67999, 92507, 92508, 92522, 92524, 97799

*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

VIII. REFERENCES

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IX. POLICY HISTORY

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MP 1.144	**06/16/2020 Consensus Review.** Policy statement unchanged. Coding, Product Variation, Benefit Variation, and Disclaimer updated. References reviewed.
	12/11/2020 Administrative Update. Removed deleted code 19324 & 19366
	04/13/2021 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.
	08/17/2021 Deleted code 19303 from policy. Placed 19350 into non-covered table. Will use 19318 for FtM reduction mammaplasty.
	12/05/2022 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.
	10/23/2023 Minor Review. Deleted age requirement to allow for adolescents. For adults, 6 months of hormone therapy as appropriate to individual’s goals. For adolescents, 12 months of hormone therapy. Adolescents need a biopsychosocial assessment. Clarified that qualified healthcare professional would have a postgraduate degree. No longer have criteria point that one must live in gender role for 12 months. Other criteria points added regarding possible causes of apparent gender incongruence as well as mental and physical health conditions that could negatively impact gender-affirming treatments. Previous interventions that were considered cosmetic may now be considered MN if the intervention is expected to effectively treat the individual’s gender incongruence and/or dysphoria. Allowance for detransition. Updated background, rationale, coding table, references, and appendix
	11/06/2024 Minor Review. Updated clinical benefit. Certain requirements have been moved into the recommendation letter; other formatting changes. Updated references, cross references, and appendix. No changes to coding.
	05/08/2025 Administrative Update. Added 11920, 11952 to coding table
	08/13/2025 Administrative Update. Removed Benefit Variations Section and updated Disclaimer.

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Appendix

DSM-5-TR 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.

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.