LifeWise
Health Plan of Washington

MEDICAL POLICY – 7.01.557
Gender Transition/Affirmation Surgery and Related Services

Effective Date:	Nov. 1, 2024
Last Revised:	Oct. 21, 2024
Replaces:	N/A

RELATED MEDICAL POLICIES:

5.01.625	Gonadotropin Releasing Hormone (GnRH) Analogs
5.01.605	Medical Necessity Criteria for Pharmacy Edits
8.03.505	Speech Therapy
10.01.514	Cosmetic and Reconstructive Services
11.01.524	Site of Service: Select Surgical Procedures

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∞ Clicking this icon returns you to the hyperlink's menu above.

Introduction

Gender transition or affirmation is the process of changing the gender characteristics a person was born with to the gender characteristics a person identifies with. Gender transition/affirmation surgery is one of the last steps in this process. This surgery changes sexual characteristics – the genitals and breasts, and in some cases other body areas such as the face or trunk (often referred to as feminization and masculinization surgery) – so they align with the preferred gender. Because these surgeries cannot be easily reversed, they are usually done at the end of a long-term process involving the accurate diagnosis of gender dysphoria, counseling about treatment options, and helping the person get ready for hormone treatment when desired and for surgery. This policy describes the procedures that are covered as part of gender transition/affirmation surgery and the criteria that are required for coverage.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Refer to member contract language or call customer service to determine which gender transition/affirmation surgeries are covered by the individual's Plan.
This medical policy provides coverage criteria for those gender transition/affirmation surgeries that are covered by the Plan.

Most plans cover mastectomy or breast reduction, augmentation mammoplasty, genital surgery, and hair removal related to genital surgery. Many plans also cover additional gender transition/affirmation surgeries for feminization, masculinization, or transition to non-binary, such as facial feminization or masculinization, body contouring, breast augmentation following the initial augmentation mammoplasty, voice surgery, and hair removal not related to genital surgery, including facility and anesthesia charges related to the surgery. Please refer to the member contract language or call customer service to determine what coverage the individual's plan has.

Some plans have customized benefits or criteria for coverage, and some plans exclude coverage of some or all gender transition/affirmation services. Please refer to the member contract language or call customer service to determine whether the individual's plan has customized benefit coverage or criteria or exclusions.

Some member contracts may use alternate terms for gender transition/affirmation, such as gender confirmation, gender change, gender reassignment, or transgender.

This policy applies to any of the following:

SURGICAL SERVICES

COVERAGE OF CHANGES OR MODIFICATION TO PREVIOUS SURGERY

OTHER GENDER TRANSITION/AFFIRMATION SERVICES

GUIDELINES

We will review for medical necessity ALL elective procedures addressed in this policy. In addition, the following services are also subject to site of service review:

- **Breast reduction**
- **Laparoscopic-assisted vaginal hysterectomy**
- **Rhinoplasty**
- **Vaginal hysterectomy**

Site of service is defined as the location where the surgical procedure is performed, such as an off campus-outpatient hospital or medical center, an on campus-outpatient hospital or medical center, an ambulatory surgical center, or an inpatient hospital or medical center.

Site of Service for Elective Surgical Procedures	Medical Necessity
Medically necessary sites of service: • **Off campus-outpatient hospital/medical center** • **On campus-outpatient hospital/medical center** • **Ambulatory surgical center**	**Certain elective surgical procedures will be covered in the most appropriate, safe, and cost-effective site. These are the preferred medically necessary sites of service for certain elective surgical procedures.**
Inpatient hospital/medical center	**Certain elective surgical procedures will be covered in the most appropriate, safe, and cost-effective site. This site is considered medically necessary only when the patient has a clinical condition which puts him or her at increased risk for complications including any of the following (this list may not be all inclusive):** ○ **Anesthesia Risk** ○ ASA classification III or higher (see definition) ○ Personal history of complication of anesthesia ○ Documentation of alcohol dependence or history of cocaine use ○ Prolonged surgery (>3 hours) ○ **Cardiovascular Risk** ○ Uncompensated chronic heart failure (**NYHA class** III or IV)

Site of Service for Elective Surgical Procedures	Medical Necessity
	○ Recent history of myocardial infarction (MI) (<3 months) ○ Poorly controlled, resistant hypertension* ○ Recent history of cerebrovascular accident (< 3 months) ○ Increased risk for cardiac ischemia (drug eluting stent placed < 1 year or angioplasty <90 days) ○ Symptomatic cardiac arrhythmia despite medication ○ Significant valvular heart disease ○ **Liver Risk** ○ Advanced liver disease (MELD Score > 8)** ○ **Pulmonary Risk** ○ Chronic obstructive pulmonary disease (COPD) (FEV1 <50%) ○ Poorly controlled asthma (FEV1 <80% despite treatment) ○ Moderate to severe obstructive sleep apnea (OSA)*** ○ **Renal Risk** ○ End stage renal disease (on dialysis) ○ **Other** ○ Morbid obesity (BMI ≥ 50) ○ Pregnancy ○ Bleeding disorder (requiring replacement factor, blood products, or special infusion product [DDAVP**** does not meet this criterion]) ○ Anticipated need for transfusion(s) **Note:** * 3 or more drugs to control blood pressure ** https://reference.medscape.com/calculator/meld-score-end-stage-liver-disease *** Moderate-AHI≥15 and ≤ 30, Severe-AHI ≥30 ****DDAVP-Deamino-Delta-D-Arginine Vasopressin (Desmopressin)
Inpatient hospital/medical center	**This site of service is considered NOT medically necessary for certain elective surgical procedures when the site of service criteria listed above in this policy are not met.**

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)

• **Breast/chest or "top surgery", mastectomy or breast reduction for:**
  ○ **Female to male patients**
  ○ **Female to non-binary/gender neutral patients**
• **Initial augmentation mammoplasty/breast augmentation (implants and/or lipofilling) for:**
  ○ **Male to female patients**
	One letter of recommendation or support for the surgery, or medical record documentation recommending or supporting the surgery, from a licensed mental health professional:
	• For prospective requests, this letter or medical record documentation must be based on a pre-surgery evaluation or psychotherapy or mental health treatment conducted within the last 12 months. (See Guidelines below)
	• For retrospective requests, this letter or medical record documentation must be based on an evaluation or psychotherapy or mental health treatment in the 12 months immediately preceding the surgery. (See Guidelines below)
	AND
	• Diagnosis of gender dysphoria (formerly gender identity disorder) confirmed by the licensed mental health professional
	AND
	• Individual is aged 18 years or older
	
	(See **Additional Information** below)

Genital or "bottom surgery": • **Clitoroplasty** • **Hysterectomy** • **Labiaplasty** • **Metoidioplasty** • **Orchiectomy** • **Penectomy in male to female patients, or as appropriate for male to non-binary/gender neutral patients** • **Penile protheses for female to male patients** • **Phalloplasty**	One letter of recommendation or support for the surgery, or medical record documentation recommending or supporting the surgery, from a licensed mental health professional. • For prospective requests, the letter or medical record documentation must be based on a pre-surgery evaluation or psychotherapy or mental health treatment conducted within the last 12 months. (See Guidelines below) • For retrospective requests, the letter or medical record documentation must be based on an evaluation or psychotherapy or mental health treatment in the 12 months immediately preceding the surgery. (See Guidelines below) **AND** • Diagnosis of gender dysphoria (formerly gender identity disorder) confirmed by the licensed mental health professionals **AND**

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)
• **Placement of testicular prostheses for female to male patients** • **Salpingo-oophorectomy** • **Scrotoplasty** • **Urethroplasty** • **Vaginectomy** • **Vaginoplasty**	• Individual is aged 18 years or older (See **Additional Information** below)
• **Additional breast augmentation, and breast/chest or genital cosmetic procedures, for feminization or masculinization or non-binary transition (previously referred to as "cosmetic" surgeries or procedures)** • **Non-breast/chest surgeries or procedures** • **Non-genital surgeries or procedures** • **Hair transplantation/ grafting**	One letter of recommendation or support for the surgery or procedure, or medical record documentation recommending or supporting the surgery or procedure, from a licensed mental health professional: • For prospective requests, this letter or medical record documentation must be based on a pre-surgery or pre-procedure evaluation or psychotherapy or mental health treatment conducted within the last 12 months (See **Guidelines** below) • For retrospective requests, this letter or medical record documentation must be based on an evaluation or psychotherapy or mental health treatment in the 12 months immediately preceding the surgery or procedure. (See **Guidelines** below) **AND** • Diagnosis of gender dysphoria (formerly gender identity disorder) confirmed by the licensed mental health professional **AND** • Individual is aged 18 years or older **AND** • There is no documentation or indication that the surgery or procedure is being done for any reason other than feminization, masculinization, or non-binary transition, (e.g., to improve appearance unrelated to gender transition/affirmation, or to reverse the appearance of normal aging, or to achieve appearance comparable to certain celebrities, or to correct medical or surgical problems unrelated to gender transition/affirmation), (however, if potentially indicated for

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)
	other reasons, the surgery or procedure might be covered under a different benefit; refer to member contract language) (See **Additional Information** below) **Surgeries that may be considered feminizing, masculinizing, for non-binary transition, or non-covered cosmetic procedures, depending on the individual's plan, include but are not limited to the following:** • Blepharoplasty • Body contouring • Breast augmentation after initial augmentation mammoplasty • Facial feminization surgery • Facial masculinization surgery • Forehead brow lift • Gluteal augmentation • Hair grafts/transplants • Hairline relocation/modification • Lip enhancement or reduction • Lipofilling • Liposuction • Pectoral implants • Reduction thyroid chondroplasty • Rhinoplasty or nose implants • Skin resurfacing • Voice modification surgery (vocal cords surgery)
Hair removal (by laser or electrolysis) prior to genital surgery	• Genital surgery for gender affirmation has been authorized under a Company plan within the last 12 months **OR** • Confirmation of the diagnosis of Gender Dysphoria, and verification (via a statement) or demonstration (via a listing of the individual's criteria that are met) that all diagnostic criteria for Gender Dysphoria are met as specified in the current version of the Diagnostic and Statistical Manual of Mental Disorders

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)
	(DSM), by a physician, nurse practitioner, physician assistant, or licensed mental health professional **AND** • Individual is aged 18 years or older **AND** • Documentation that hair removal will be from existing genital sites where surgery will be performed **AND/OR** • Documentation that hair removal will be from donor tissue that will be utilized to form female or male genitals **AND** • Hair removal will be done in a clinic or office setting outside of a hospital **AND** • Hair removal will be done by a physician, nurse practitioner, physician assistant, or by a professional who is licensed, certified, registered, or otherwise approved by the state for hair removal (e.g., a state licensed or certified esthetician or aesthetician, electrologist, medical esthetician or aesthetician, or medical electrologist), or by a provider who is a CPE (Certified Professional Electrologist), or at a clinic or so-called spa that is state licensed, certified, or approved for hair removal) **Hair removal for any other reasons or from any other body areas is considered a feminization or non-binary or cosmetic procedure, and therefore, member contract stipulations for feminization/non-binary or cosmetic procedures (either contract exclusion or coverage criteria, whichever is applicable for the individual's health plan) apply.**
Facial or body or extremity hair removal (by laser or electrolysis) for feminization or non-binary	• Surgery (not hair removal or medical tattooing) for gender affirmation has been authorized under a Company plan within the last 12 months **OR**

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)
transition not related to genital surgery	• Confirmation of the diagnosis of Gender Dysphoria, and verification (via a statement) or demonstration (via a listing or description of the individual's criteria that are met) that all diagnostic criteria for Gender Dysphoria are met as specified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), by a physician, nurse practitioner, physician assistant, or licensed mental health professional **AND** • Individual is aged 18 years or older **AND** • Hair removal will be done in a clinic or office setting outside of a hospital **AND** • Hair removal will be done by a physician, nurse practitioner, physician assistant, or by a professional who is licensed, certified, registered, or otherwise approved by the state for hair removal (e.g., a state licensed esthetician or aesthetician, electrologist, medical esthetician or aesthetician, or medical electrologist), or by a provider who is a CPE (Certified Professional Electrologist), or at a clinic or so-called spa that is state licensed, certified, or approved for hair removal **AND** • There is no documentation or indication that hair removal is being done for any reason other than gender affirming feminization or non-binary transition (e.g., to improve appearance unrelated to gender transition/affirmation, or to reverse the appearance of normal aging or to achieve appearance comparable to certain celebrities), (however, if potentially indicated for other reasons, hair removal might be covered under a different benefit; refer to member contract language) **Member contract stipulations for feminization/non-binary or cosmetic procedures (either contract exclusion or coverage**

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)
	criteria, whichever is applicable for the individual's health plan) apply. **If the location of hair removal is not specified, then hair removal is presumed to be facial, body, or extremity hair removal not related to genital surgery.** **For plans that cover hair removal not related to genital surgery, facial/body/extremity hair removal for masculinization that is not related to genital surgery is considered to be not medically necessary.** (See **Additional Information** below)
Medical tattooing	• Medical tattooing will be done in conjunction with or after surgery or a procedure that has been authorized under a Company plan or which satisfies criteria for coverage **AND** • The medical tattooing is intended for, and is expected to result in, a more feminine or masculine or non-binary appearance **AND** • There is no documentation or indication that medical tattooing is being done for any reason other than gender affirming feminization, masculinization, or non-binary transition (e.g., to improve appearance unrelated to gender transition/affirmation, or to reverse the appearance of normal aging, or to achieve appearance comparable to certain celebrities), (however, if potentially indicated for other reasons, the medical tattooing might be covered under a different benefit; refer to member contract language) **AND** • The medical tattooing is performed by a licensed healthcare provider

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)
	(See **Additional Information** below)
Uterine transplantation	**Uterine transplantation is considered investigational for gender transition/affirmation.**
Penile transplantation	**Penile transplantation (as distinct from penile prostheses) is considered investigational for gender transition/affirmation.**
Revision of appearance after previous gender transition/affirmation surgery due to dissatisfaction with the outcome or to modify or enhance the desired appearance, in the absence of pain or functional impairment	• Documentation from a professional (e.g., surgeon, primary care provider, mental health clinician) who has evaluated the individual or has been treating the individual, that the proposed revision is expected to improve the individual's feminine, masculine, or non-binary appearance, whichever is appropriate, and, that the revision is expected to decrease the individual's gender dysphoria **OR** • The previous surgery resulted in a significant deformity that is not a component of normal anatomy (e.g., dog ears after mastectomy or symmastia after breast augmentation), verified on a physical examination **AND** • There is no documentation or indication that the surgery or procedure is being pursued for reasons unrelated to feminization, masculinization, or non-binary transition, e.g., to improve general appearance, or to reverse the appearance of normal aging, or to correct medical or surgical problems unrelated to feminization, masculinization, or non-binary transition (however, if potentially indicated for other reasons, the surgery or procedure might be covered under a different benefit; refer to member contract language) **AND** • If the original surgery for which revision is proposed was done when the individual was not covered by a Company plan, then coverage for the original gender transition/affirmation surgery is available under the individual's current health benefit plan

Surgical Services	Medically Necessary (except when otherwise stated in member contract language)
	Note: Revision of appearance is considered not medically necessary when the original surgery was determined to be not medically necessary except when a complication is causing or is likely to cause a medical or surgical emergency. (See **Additional Information** below)
Correction of incomplete or incorrectly done: • **Non-breast/chest surgeries** • **Non-genital surgeries** • **Additional breast augmentation**	• Documentation from a surgeon that previously authorized gender transition/affirmation surgery was not satisfactory due to not being completed, or due to having been done incorrectly **AND** • Documentation by the surgeon of the specific component or components of the surgery that were not done which should have been done, or what specifically was done incorrectly that requires surgical correction **AND** • If the incomplete or incorrectly done surgery was done when the individual was not covered by a Company plan, then coverage for the original gender transition/affirmation surgery is available under the individual's current health benefit plan **Note:** Correction of incomplete or incorrectly done surgery is considered not medically necessary when the original surgery was determined to be not medically necessary except when a complication is causing or is likely to cause a medical or surgical emergency. (See **Additional Information** below)

Coverage of changes or modifications to previous surgery(ies)	Medically Necessary (except when otherwise stated in member contract language)
Correction of incomplete or incorrectly done: • **Breast/chest** • **Genital surgeries**	• Documentation from a surgeon that previously authorized gender transition/affirmation surgery was not satisfactory due to not being completed, or due to having been done incorrectly

Coverage of changes or modifications to previous surgery(ies)	Medically Necessary (except when otherwise stated in member contract language)
	AND • Documentation by the surgeon of the specific component or components of the surgery that were not done which should have been done, or what specifically was done incorrectly that requires surgical correction **AND** • If the incomplete or incorrectly done surgery was done when the individual was not covered by a Company plan, then coverage for the original gender transition/affirmation surgery is available under the individual's current health benefit plan **Note:** Correction of incomplete or incorrectly done surgery is considered not medically necessary when the original surgery was determined to be not medically necessary except when a complication is causing or is likely to cause a medical or surgical emergency. (See **Additional Information** below)
Reversal	**Surgery to reverse partially or fully completed gender transition/affirmation surgery (which may include restoring anatomic features of the gender that was assigned at birth) is considered not medically necessary except in the case of a serious medical barrier to completing gender transition/affirmation, or the development of a serious medical condition necessitating reversal.** **Surgery satisfying the above requirements that is proposed for reversal of partially or fully completed gender transition/affirmation surgery that was done when the individual was not covered by a Company plan, is considered medically necessary only if coverage for the original gender transition/affirmation surgery is available under the individual's current health benefit plan, or if there is a complication that is causing or is likely to cause a medical or surgical emergency.**

Coverage of changes or modifications to previous surgery(ies)	Medically Necessary (except when otherwise stated in member contract language)
	Note: Reversal of partially or fully completed gender transition/affirmation surgery is considered not medically necessary when the original surgery was determined to be not medically necessary except when a complication is causing or is likely to cause a medical or surgical emergency. (See **Additional Information** below)
• **Correction or repair of complications** • **Revision due to complications** • **Reversal and redoing due to complications**	**Surgery to correct or repair complications of previously authorized gender transition/affirmation surgery is considered medically necessary for complications that cause pain or functional impairment or are likely to cause functional impairment or a serious medical or surgical condition (e.g., potential complications of wound dehiscence) if not repaired.** **Surgery to revise, or to reverse and redo, specific previously authorized gender transition/affirmation procedures, is considered medically necessary when correction or repair of complications that cause pain or functional impairment requires revision or reversal and redoing of the original procedure. (Example: Baker IV contracture after breast augmentation necessitates removal of the implants, and replacement with smaller implants.)** **Surgery satisfying the above requirements that is proposed for complications of gender transition/affirmation surgery that was done when the individual was not covered by a Company plan, is considered medically necessary only if coverage for the original gender transition/affirmation surgery is available under the individual's current health benefit plan, or if the complication is causing or is likely to cause a medical or surgical emergency.** **Note**: Correction or repair of complications is considered not medically necessary when the original surgery was determined to be not medically

Coverage of changes or modifications to previous surgery(ies)	Medically Necessary (except when otherwise stated in member contract language)
	necessary except when a complication is causing or is likely to cause a medical or surgical emergency. (See **Additional Information** below)

Other gender transition/affirmation services	Medical Necessity Criteria
Preservation of fertility	**Procedures for preservation of fertility, e.g., procurement, cryopreservation, and storage of sperm, oocytes, or embryos, performed prior to gender transition/affirmation surgery, are considered medically necessary for gender transition/affirmation with the exception of plans which do not include a benefit for assisted reproduction services; refer to member contract language.**
Non-surgical gender transition/affirmation services	• For voice therapy, refer to Medical Policy **8.03.505 Speech Therapy** • For hormone therapy, refer to Medical Policies **5.01.625 Gonadotropin Releasing Hormone (GnRH) Analogs**, and **5.01.605 Medical Necessity Criteria for Pharmacy Edits** • For counseling/psychotherapy and psychiatric medication treatment, refer to member contract language

Guidelines	Coverage Clarification
Recommendations by Licensed Mental Health Professionals	• Evaluations or psychotherapy or mental health treatment must be performed by, and letters of recommendation or support or medical record documentation written by, professionals who are state licensed to practice independently (without supervision) as master's degree level mental health clinicians, doctoral level mental health clinicians, psychiatric nurse practitioners, psychiatric physician assistants, or psychiatrists.

Guidelines	Coverage Clarification
	○ Exceptions: Evaluations or psychotherapy or mental health treatment may be performed by, and letters of recommendation or support written by, state licensed master's and doctoral level mental health clinicians who are not licensed to practice independently (e.g., Associate or limited license mental health clinicians; interns; residents) if master's degree level or doctoral level mental health professionals who are state licensed to practice independently co-sign the letters or medical record documentation • Evaluations or psychotherapy or mental health treatment may be in-person or virtual. • Letters of recommendation or support or medical record documentation must be specific to the individual; letters or medical record documentation which are generic or templated do not satisfy this requirement. • The required minimum content of the mental health recommendation letters or medical record documentation is as follows: ○ A recommendation supporting the individual's desire to proceed with the specific gender transition/affirmation surgery or procedure that is proposed or to proceed with gender transition/affirmation surgery in general ○ A date or dates within the last 12 months when the mental health professional most recently evaluated or treated the individual; alternately, an explanation of the frequency of evaluation or treatment sessions which demonstrates that the mental health professional evaluated or treated the individual within the previous 12 months (See **Additional Information** below) ○ Confirmation of the diagnosis of Gender Dysphoria, and verification (via a statement) or demonstration (via a listing or description of the individual's criteria that are met) that all diagnostic criteria for Gender Dysphoria are met as specified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

Guidelines	Coverage Clarification
	○ A summary of the history of the individual's gender incongruence and gender identity transition including at a minimum: when the individual became aware of, or how long the individual has been aware of, gender incongruence; verification or demonstration of persistence of gender incongruence or gender dysphoria over time; verification or demonstration of persistence over time of the desire to transition to the desired gender identity; actions taken, if any, to transition to, or live or function as, the desired gender identity ○ If the recommendation supports proceeding with surgery, verification or demonstration that the individual's decision to have the surgery is well thought out; alternately, the individual's decision to have surgery will be considered to be well thought out if the individual has, for the immediately preceding 12 months, either undergone hormone therapy appropriate for the desired gender identity, or lived full-time in the gender role appropriate for the desired gender identity ○ If the recommendation supports proceeding with surgery, verification or demonstration that the individual's decision to have the surgery is not a symptom of or the product of any mental disorder or condition or mental health concern other than gender dysphoria, or documentation that there is no evidence of any other mental disorder or condition or mental health concern other than gender dysphoria; alternately, if any mental disorders or conditions or mental health concerns other than gender dysphoria are reported or identified, including depression or anxiety that are not symptoms of or due to gender dysphoria, verification or demonstration that such disorders or condition or concerns are reasonably well-controlled, are not influencing the decision to proceed with surgery, and are not contraindications to surgery ○ If any co-morbid psychiatric disorders are reported or identified which can cause or have caused impaired reality testing – e.g., psychotic disorders, bipolar disorder with

Guidelines	Coverage Clarification
	significant manic episodes, dissociative identify disorder, borderline identity disorder – verification or demonstration that reality testing is intact, that such disorders are well-stabilized, and that they are not contraindications to surgery ○ If the recommendation supports proceeding with surgery, verification or demonstration that the individual has the capacity to make a fully informed decision about proceeding with the surgery; alternately, verification that the individual understands the potential risks and benefits of the surgery will be considered to demonstrate that the individual has the capacity to make a fully informed decision about proceeding with the surgery
Additional timing requirements for mental health recommendations	Additional timing requirements for mental health recommendations (letter or medical record documentation) after the first authorized gender transition/affirmation surgery or procedure when the gender transition/affirmation surgical process is spaced out over time: • For gender transition/affirmation surgery that requires a mental health recommendation, a new mental health recommendation with all of the information noted in the Recommendations by Licensed Mental Health Professionals section above is required for any authorized surgery or procedure that is not done within two years of the date when the first surgery or procedure that required a mental health recommendation was authorized. (See **Additional Information**) The two-year period ends two years after the date of the first authorized surgery or procedure that required a mental health recommendation, even if additional surgeries or procedures that require mental health recommendations are authorized during the two-year period. • Because authorizations for gender transition/affirmation surgery and procedures are for twelve months, a new authorization request will have to be submitted for any authorized surgery or procedure which requires a mental health recommendation that is not able to be done within twelve months of the date when it was authorized. A new mental

Guidelines	Coverage Clarification
	health recommendation is required if the time since the original authorization is more than two years. Otherwise, for additional gender transition/affirmation surgery or procedures after the first authorized surgery: • If the first authorized gender transition/affirmation surgery or procedure was surgery or a procedure that required a mental health recommendation (e.g., breast/chest surgery or facial surgery or genital surgery), then no additional mental health recommendations are required for any additional gender transition/affirmation surgeries or procedures that are requested within two years of the date when the first surgery was authorized. This includes different types of surgery over time (e.g., initial breast/chest surgery, and subsequent facial surgery, and/or subsequent genital surgery) but within the two-year period, or surgery that is done in two or more stages (e.g., multi-stage facial or genital surgery) within the two-year period. • If the first authorized gender transition/affirmation surgery or procedure was surgery or a procedure that required a mental health recommendation, then a new mental health recommendation with all of the information noted in the Recommendations by Licensed Mental Health Professionals section above is required for any subsequent gender transition/affirmation surgery or procedure that requires a mental health recommendation and that is requested more than two years after the date when the first surgery or procedure was authorized, even if additional surgeries or procedures that require mental health recommendations are authorized during that two-year period. • If the first authorized gender transition/affirmation procedure was not surgery or a procedure that required a mental health recommendation (e.g., hair removal), then a mental health recommendation with all of the information noted in the Recommendations by Licensed Mental Health Professionals

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	section above is required for the first gender transition/affirmation surgery or procedure that does require a mental health recommendation. The stipulations above then apply for any subsequent gender transition/affirmation surgery or procedure that requires a mental health recommendation. • When the gender transition/affirmation surgical process is spaced out over time and the initial/previous gender transition/affirmation surgery or procedure that would have required a mental health recommendation was done when the individual was not covered by a Company plan, then the full requirements for a mental health recommendation applicable for the proposed surgery or procedure must be met, unless a mental health recommendation for the previous surgery or procedure is submitted, satisfies the requirements of this policy for the previous surgery or procedure, and the previous surgery or procedure was done within two years prior to the date of the request. (See **Additional Information** below)
DSM-5 Criteria for Gender Dysphoria in Adults and Adolescents	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: • 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) • 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) • A strong desire for the primary and/or secondary sex characteristics of the other gender • A strong desire to be of the other gender (or some alternative gender different from one's assigned gender) • A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)

Guidelines	Coverage Clarification
	• 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) • The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning

Additional Information	Coverage Clarification
All surgery and procedures	• Authorizations for all surgery and procedures are valid for 12 months from the date of authorization. A new authorization must be requested for any authorized surgery or procedure that is not done or completed within twelve months of the date when it was authorized. • All requirements must be met for each new request for coverage of surgery or a procedure, with the possible exception of mental health recommendations for surgery or procedures for which coverage is requested within two years of the date when the first authorized gender transition/affirmation surgery or procedure was authorized. (See **Additional timing requirements** for mental health recommendations above)
Mastectomy or breast reduction	• A trial of hormone therapy is not a pre-requisite for qualifying for a mastectomy. • Nipple/areola reconstruction or nipple grafting (aka free nipple grafting), are considered medically necessary as a component of covered mastectomy when done at the same time as mastectomy. When done at a later date, they are considered to be masculinization or cosmetic procedures, and therefore subject to the plan's coverage or exclusion of such procedures. • Chest contouring (aka chest masculinization), chest liposuction, or chest suction assisted lipectomy, is considered medically necessary as a component of covered mastectomy when done at the same time as mastectomy. When done at a later date, it is considered to be a masculinization or cosmetic procedure, and therefore subject to the Plan's coverage or exclusion of such procedures.

Additional Information	Coverage Clarification
	• Nerve repair in conjunction with covered mastectomy is considered medically necessary as a component of mastectomy to repair nerve damage that can occur during surgery to prevent post-mastectomy pain syndrome. • Mastectomy or additional breast reduction after initial breast reduction surgery is considered a new procedure – not the second stage of breast/chest surgery or revision of the initial surgery – because breast/chest surgery is typically not done in stages. A second stage is not typically part of the surgical plan, and mastectomy or additional breast reduction is more extensive than revision of appearance. Therefore, all criteria for mastectomy/breast reduction must be met, including a mental health recommendation letter and a pre-surgery evaluation within the specified timeframes.
Augmentation mammoplasty	• A trial of hormone therapy is not a pre-requisite for qualifying for augmentation mammoplasty. • Augmentation mammoplasty may be done via implants or fat transfer or a combination of both. • Liposuction is considered medically necessary as a component of covered augmentation mammoplasty when done at the same time as augmentation mammoplasty, for the purpose of harvesting fat tissue to be utilized for fat grafting/lipofilling for breast augmentation. When done at a later date, it is considered a feminization or cosmetic procedure, and therefore subject to the plan's coverage or exclusion of such procedures. • Mastopexy (breast lift) is considered medically necessary as a component of covered augmentation mammoplasty when done at the same time as augmentation mammoplasty. When done at a later date, it is considered a feminization or cosmetic procedure, and therefore subject to the plan's coverage or exclusion of such procedures. • Additional breast augmentation after an initial augmentation mammoplasty is considered a feminization or cosmetic procedure, and therefore subject to the plan's coverage or exclusion of such procedures.

Additional Information	Coverage Clarification
Genital surgery	• A trial of hormone therapy is not a pre-requisite for qualifying for genital surgery. • Penile prostheses are covered for gender transition/affirmation unless a plan has a specific exclusion for penile prostheses for all conditions. An exclusion for penile prostheses for sexual dysfunctions does not apply to gender transition transition/affirmation because gender dysphoria is not a sexual dysfunction.
• **Non-breast/chest surgeries or procedures** • **Non-genital surgeries or procedures**	• Computed tomography (CT) imaging for pre-surgery planning is considered medically necessary when facial feminization or masculinization surgery is determined to be medically necessary. • An otolaryngology work-up is considered medically necessary prior to covered voice modification surgery to determine if the individual is a reasonable surgical candidate for, and has realistic expectations about, the surgery. Such work-up might include evaluation by an otolaryngologist, laryngoscopy with stroboscopy, laryngeal function studies, and speech therapist/speech pathologist consultation. • Some plans may limit coverage to a list of specific surgeries or procedures; refer to member contract language.
• **Hair removal (by laser or electrolysis) prior to genital surgery** • **Facial or body or extremity hair removal not related to genital surgery**	• Local anesthesia/local nerve block in conjunction with covered hair removal is considered medically necessary. • When hair removal is done at so-called spas, the professional or professionals doing the hair removal must be one of the provider types noted above unless the spa is state licensed or certified or approved for hair removal. • A mental health recommendation is not required for hair removal. • A pre-procedure evaluation by the hair removal provider or a referring medical provider is not required for hair removal. • If the body area or areas from which hair will be removed are not specified, then it is assumed that the hair removal is facial and/or body and/or extremity hair removal, not hair removal prior to genital surgery.

Additional Information	Coverage Clarification
	• Depending on the extent of hair removal that is necessary, full hair removal can take up to a year, at a frequency of up to 3 times/week.
Medical tattooing	• In most states, licensed tattoo artists and licensed cosmetic artists are not licensed healthcare providers.
Revision of appearance after previous gender transition/affirmation surgery due to dissatisfaction with the outcome or to modify or enhance the desired appearance, in the absence of pain or functional impairment	• This also applies to scar revision. • Some self-funded group plans (group plans that are subject to ERISA – the Federal Employee Retirement Income Security Act of 1974) may cover revision of appearance of previous surgery when the individual was not on the group's health plan regardless of whether the previous surgery is covered under the current plan or would have been covered if the individual had been on the plan at that time; refer to member contract language for those groups.
Correction of incomplete or incorrectly done surgery	• Some self-funded group plans (group plans that are subject to ERISA – the Federal Employee Retirement Income Security Act of 1974) may cover correction of previous surgery when the individual was not on the group's health plan regardless of whether the previous surgery is covered under the current plan or would have been covered if the individual had been on the plan at that time; refer to member contract language for those groups.
Reversal	• Some self-funded group plans (group plans that are subject to ERISA – the Federal Employee Retirement Income Security Act of 1974) may cover reversal of appearance of previous surgery when the individual was not on the group's health plan regardless of whether the previous surgery is covered under the current plan or would have been covered if the individual had been on the plan at that time; refer to member contract language for those groups.
• **Correction or repair of complications** • **Revision due to complications** • **Reversal and redoing due to complications**	• If member contract terms for coverage of complications of surgery differ from the criteria above, then the member contract terms determine coverage (e.g., complications are covered under the same conditions as complications of other services or surgery).

Additional Information	Coverage Clarification
	• Correction or Repair of Complications/Revision or Reversal Due to Complications are considered not medically necessary when the original surgery was determined to be not medically necessary except when a complication is causing or is likely to cause a medical or surgical emergency. • Some self-funded group plans (group plans that are subject to ERISA – the Federal Employee Retirement Income Security Act of 1974) may cover surgery for complications of previous surgery done when the individual was not on the group's health plan regardless of whether the previous surgery is covered under the current plan or would have been covered if the individual had been on the plan at that time; refer to member contract language for those groups.
Recommendations by Licensed Mental Health Professionals	• Unlike physicians and nurse practitioners, physician assistants are not certified in specialties. Physician assistant specialties are determined by the specialty setting in which they are working. Psychiatric physician assistants are therefore physician assistants who are working in a psychiatric setting. • The date that a letter or medical record documentation was written does not by itself show that the mental health professional actually evaluated or treated the individual on that date. The letter or medical record documentation must therefore specify the date or dates within the previous 12 months when the mental health professional most recently evaluated or treated the individual, or must show a frequency of evaluation or treatment sessions which demonstrates that the mental health professional evaluated or treated the individual within the previous 12 months.
Additional timing requirements for mental health recommendations	• Additional timing requirements apply for all surgery or procedures that require mental health recommendations. • Some self-funded groups may have customized criteria; refer to member contract language for those groups. • For plans with customized coverage criteria that specifically use WPATH standards as medical necessity criteria, additional timing requirements are applicable only for plans that also require mental health recommendations, and only for mental

Additional Information	Coverage Clarification
	health recommendations. All WPATH criteria must be met with each requested surgery or procedure regardless of whether a plan also requires mental health recommendations.

Documentation Requirements

The patient's medical records and supporting documentation submitted for review for all surgery and procedures must document all specific medical necessity criteria that are met in the relevant section or sections above, or in the benefit criteria for plans that have customized criteria. A general statement that WPATH criteria or standards are met is not sufficient for satisfying the medical policy criteria for the specific surgery or procedure, or for satisfying the benefit criteria for plans that have customized criteria, for the specific surgery or procedure. All specific criteria for the surgery or procedure as listed in the relevant section or sections of this medical policy, or in the benefit criteria for plans that have customized criteria, must be specifically documented and satisfied. This also applies to plans that use WPATH standards as customized medical necessity criteria; all appliable WPATH medical necessity criteria must be specifically documented and satisfied.

The record should include the following:

For mastectomy for female to male or gender neutral/non-binary patients; for augmentation mammoplasty for male to female patients; for genital surgery; and for non-breast/chest surgeries, non-genital surgeries, and additional breast augmentation, for feminization or masculinization or non-binary transition for plans that cover these procedures:

- One recommendation letter or medical record documentation from a licensed mental health professional based on a pre-surgery evaluation or psychotherapy or mental health treatment within the last 12 months.
- MH recommendations must specifically verify the date of evaluation or psychotherapy or treatment within the previous 12 months. Simply dating a letter within the previous 12 months or stating the individual has been in treatment or has been seen for a certain period of time or since a certain date, does not verify an evaluation or psychotherapy or treatment within the previous 12 months.
- The required minimum content of the recommendations:
  - Confirmation of the diagnosis of gender dysphoria or gender identity disorder
  - If the recommendation supports proceeding with surgery, verification or demonstration that the individual's decision to have the surgery is well thought out; alternately, the individual's decision to have surgery will be considered to be well thought out if the

Documentation Requirements

individual has, for the immediately preceding 12 months, either undergone hormone therapy appropriate for the desired gender identity or lived in the gender role appropriate for the desired gender identity.

- If the recommendation supports proceeding with surgery, verification or demonstration that the individual's decision to have the surgery is not the product of any mental disorder other than gender dysphoria.
- If any co-morbid psychiatric disorders are reported or identified, verification or demonstration that such disorders are reasonably well-controlled and are not contraindications to surgery.
- If any co-morbid psychiatric disorders are reported or identified which can cause or have caused impaired reality testing – e.g., psychotic disorders, bipolar disorder with significant manic episodes, dissociative identify disorder, borderline identity disorder --verification or demonstration that reality testing is intact, that such disorders are well-stabilized, and that they are not contraindications to surgery.
- If the recommendation supports proceeding with surgery, verification or demonstration that the individual has the capacity to make a fully informed decision about proceeding with the surgery.

For hair removal prior to genital surgery:

- Documentation that hair removal will be from existing genital sites where surgery will be performed, or, from donor tissue that will be utilized to form female or male genitals.

Medical tattooing:

- Documentation that the medical tattooing is intended for, and is expected to result in, a more feminine or masculine or non-binary appearance, with no documentation that the medical tattooing is for any other purpose, or that it is for the purpose of enhancing features which are already clearly recognizable as feminine, masculine, or non-binary.

Correction of incomplete or incorrectly done surgery:

- Documentation that the previous surgery was incomplete or done incorrectly, including the specific component or components of the surgery that were not done which should have been done, or what specifically was done incorrectly.

Revision surgery, for plans that cover non-breast/chest surgeries, non-genital surgeries, and additional breast augmentation, for feminization or masculinization or non-binary transition:

Documentation Requirements

- Documentation that the proposed revision is expected to improve the individual's feminine, masculine, or non-binary appearance, whichever is appropriate, and, that the revision is expected to decrease the individual's gender dysphoria.

Surgery to reverse partially or fully completed gender transition/affirmation:

- Documentation of a serious medical barrier to completing gender transition/affirmation or the development of a serious medical condition necessitating reversal.

Surgery to correct or repair complications of previously authorized gender transition/affirmation surgery:

- Documentation of the specific complications that are causing pain, functional impairment, or significant deformity.

Surgery to revise, or to reverse and redo, previously authorized gender transition/affirmation surgery:

- Documentation that correction or repair of complications requires revision or undoing of the original genital or breast/chest procedure.

Coding

Code	Description
CPT	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc

Code	Description
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (list separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (list separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap

Code	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Mammaplasty, augmentation; with prosthetic implant
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
21087	Impression and custom preparation; nasal prosthesis
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece

Code	Description
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead: contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
40500	Vermilionectomy (lip shave), with mucosal advancement
40510	Excision of lip; transverse wedge excision with primary closure
40520	Excision of lip; V-excision with primary direct linear closure
40525	Excision of lip; full thickness, reconstruction with local flap (e.g., Estlander or fan)
40527	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)

Code	Description
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis, complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
55180	Scrotoplasty, complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy, simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall;
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft; laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58290	Vaginal hysterectomy, for uterus greater than 250 g

Code	Description
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
HCPCS	
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, noninflatable
ICD-10-PCS	
0U5J0ZZ	Destruction of Clitoris, Open Approach
0U5JXZZ	Destruction of Clitoris, External Approach
0U9J00Z	Drainage of Clitoris with Drainage Device, Open Approach
0U9J0ZZ	Drainage of Clitoris, Open Approach
0U9JX0Z	Drainage of Clitoris with Drainage Device, External Approach
0U9JXZZ	Drainage of Clitoris, External Approach
0UBJ0ZX	Excision of Clitoris, Open Approach, Diagnostic
0UBJXZX	Excision of Clitoris, External Approach, Diagnostic
0UBJXZZ0	Excision of Clitoris, External Approach, Excision of Clitoris, External Approach, Diagnostic, Drainage of Clitoris with Drainage Device, External Approach
0UCJ0ZZ0	Extirpation of Matter from Clitoris, Open Approach, Excision of Clitoris, External Approach, Drainage of Clitoris, External Approach
0UCJXZZ	Extirpation of Matter from Clitoris, External Approach, Extirpation of Matter from Clitoris, Open Approach, Excision of Clitoris, Open Approach, Diagnostic
0UMJXZZ	Reattachment of Clitoris, External Approach, Extirpation of Matter from Clitoris, External Approach, Excision of Clitoris, Open Approach

Code	Description
0UNJ0ZZ	Release Clitoris, Open Approach, Reattachment of Clitoris, External Approach, Excision of Clitoris, External Approach, Diagnostic
0UNJXZZ	Release Clitoris, External Approach
0UQG0ZZ	Repair Vagina, Open Approach
0UQJ0ZZ	Repair Clitoris, Open Approach
0UQJXZZ	Repair Clitoris, External Approach
0UTG0ZZ	Resection of Vagina, Open Approach
0UTG4ZZ	Resection of Vagina, Percutaneous Endoscopic Approach
0UTG7ZZ	Resection of Vagina, Via Natural or Artificial Opening
0UTG8ZZ	Resection of Vagina, Via Natural or Artificial Opening Endoscopic
0UTJ0ZZ	Resection of Clitoris, Open Approach
0UTJXZZ	Resection of Clitoris, External Approach
0UTM0ZZ	Resection of Vulva, Open Approach
0UTMXZZ	Resection of Vulva, External Approach
0UUJ07Z	Supplement Clitoris with Autologous Tissue Substitute, Open Approach
0UUJ0JZ	Supplement Clitoris with Synthetic Substitute, Open Approach
0UUJ0KZ	Supplement Clitoris with Nonautologous Tissue Substitute, Open Approach
0UUJX7Z	Supplement Clitoris with Autologous Tissue Substitute, External Approach
0UUJXJZ	Supplement Clitoris with Synthetic Substitute, External Approach
0UUJXKZ	Supplement Clitoris with Nonautologous Tissue Substitute, External Approach
0VR90JZ	Replacement of Right Testis with Synthetic Substitute, Open Approach
0VRB0JZ	Replacement of Left Testis with Synthetic Substitute, Open Approach
0VRC0JZ	Replacement of Bilateral Testes with Synthetic Substitute, Open Approach
0VTS0ZZ	Resection of Penis, Open Approach
0VTS4ZZ	Resection of Penis, Percutaneous Endoscopic Approach
0VTSXZZ	Resection of Penis, External Approach
0VUS07Z	Supplement Penis with Autologous Tissue Substitute, Open Approach

Code	Description
0VUS0JZ	Supplement Penis with Synthetic Substitute, Open Approach
0VUS0KZ	Supplement Penis with Nonautologous Tissue Substitute, Open Approach
0VUS47Z	Supplement Penis with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0VUS4JZ	Supplement Penis with Synthetic Substitute, Percutaneous Endoscopic Approach
0VUS4KZ	Supplement Penis with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0W4M070	Creation of Vagina in Male Perineum with Autologous Tissue Substitute, Open Approach
0W4M0J0	Creation of Vagina in Male Perineum with Synthetic Substitute, Open Approach
0W4M0K0	Creation of Vagina in Male Perineum with Nonautologous Tissue Substitute, Open Approach
0W4M0Z0	Creation of Vagina in Male Perineum, Open Approach
0W4N071	Creation of Penis in Female Perineum with Autologous Tissue Substitute, Open Approach
0W4N0J1	Creation of Penis in Female Perineum with Synthetic Substitute, Open Approach
0W4N0K1	Creation of Penis in Female Perineum with Nonautologous Tissue Substitute, Open Approach
0W4N0Z1	Creation of Penis in Female Perineum, Open Approach

Related Information

Definition of Terms

Company plan: Any plan offered by the health insurance company.

Cosmetic: In this policy, cosmetic services are those which are primarily intended to preserve or improve appearance. Cosmetic surgery is performed to reshape structures of the body in order to change or improve the patient's appearance, not to improve functioning or to improve or restore a specific bodily function that has not been working properly.

Gender: This term refers to the perception of a person's sex on the part of society as male or female.[4]

Gender dysphoria: An individual's affective/cognitive discontent with the assigned gender; the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender.[1]

Gender identity: Refers to an individual's personal sense of self as male or female. It usually develops by age 3, is concordant with a person's sex and gender, and remains stable over the lifetime. For a small number of individuals, it can change later in life.[4]

Pre-surgery evaluation: An evaluation that is done before surgery is done.

Transgender: People who have a gender identity that is discordant with their anatomical sex.[4]

Transsexual: Transgender people who make their perceived gender and/or anatomical sex conform to their gender identity through strategies such as dress, grooming, hormone use and/or surgery (known as gender reassignment).[4]

Description

Gender reassignment surgery may be part of a treatment plan for gender dysphoria.

Gender dysphoria is defined as, an individual's affective/cognitive discontent with the assigned gender; the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender.[1]

Gender reassignment surgery is intended to be a permanent change to a patient's sexual identity and is not 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 (gender reassignment therapy) that includes an extensive case history; gynecological, endocrinological and urological examination; and a clinical psychiatric/psychological examination by a qualified mental health professional.

Mental health professionals play a strong role in working with individuals with gender dysphoria, as they need to diagnose gender dysphoria and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, provide psychotherapy and assess eligibility and readiness for hormone and surgical therapy, to make recommendations to medical and surgical colleagues regarding care, and provide continuing psychiatric care after gender reassignment intervention as major psychological adjustments are necessary.

After diagnosis, the therapeutic approach may include 3 elements: hormones of the desired gender, real life experience in the desired role and surgery to change the genitalia and other

gender characteristics. Hormone therapy and gender reassignment surgery are superficial, albeit irreversible changes, in comparison to the major psychological adjustments necessary in changing gender. Treatment should concentrate on the psychological adjustment, with hormone therapy and gender-reassignment surgery being viewed as confirmatory procedures dependent on adequate psychological adjustment.

Physical interventions fall into 3 categories or stages:

1. Fully reversible interventions. These involve the use of LHRH agonists or medroxyprogesterone to suppress estrogen or testosterone production, and consequently to delay the physical changes of puberty.
2. Partially reversible interventions. These include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males. Reversal may involve surgical intervention.
3. Irreversible interventions. These are surgical procedures.

Benefit Application

Coverage for gender transition/affirmation surgery includes mastectomy or breast reduction, augmentation mammoplasty, genital surgery, hair removal related to genital surgery, non-breast/chest surgeries or procedures, non-genital surgeries or procedures, additional breast augmentation, hair removal not related to genital surgery, and breast/chest or genital cosmetic procedures, including facility and anesthesia charges related to the surgery. All Washington individual plans and most Washington employer sponsored group plans provide this coverage. Alaska individual plans, and Alaska employer sponsored group plans, provide coverage for gender transition/affirmation mastectomy or breast reduction, augmentation mammoplasty, genital surgery, and hair removal related to genital surgery.

Some plans have different benefits or criteria for coverage, and some plans exclude coverage of some or all gender transition/affirmation services.

Some plans exclude coverage of penile prostheses/implants for sexual dysfunction. Sexual dysfunction is not gender dysphoria and therefore, an exclusion for sexual dysfunction is not an exclusion for gender dysphoria.

Refer to member contract language or call customer service to determine benefit coverage.

Evidence Review

The American Psychiatric Association (APA) does not have practice guidelines for gender reassignment surgery. The APA board of trustees formed a task force in 2011 to perform a critical review of the literature on the treatment of Gender Identity Disorder. The task force published a report in the American Journal of Psychiatry in August 2012. The report concluded that "for adults sufficient evidence exists for the development of recommendations in the form of an APA practice guideline, with gaps in the research database filled in by clinical consensus". The APA practice guideline is currently under development.

The APA raised concerns about WPATH Standards of Care version 6 in that it did not cite its underlying evidence base, nor indicate the level of evidence upon which its standards were based. The WPATH Standard of Care version 7 cites underlying evidence, but not the level of evidence. The APA task force report also states no professional organization of mental health practitioners provides recommendations on the role of mental health professionals in a multidisciplinary team approach to providing medical services to individuals with gender dysphoria. Although WPATH is not a professional organization of mental health professionals, it counts many mental health professionals among its members, including psychologists, psychiatrists and psychiatric social workers.

The World Professional Association for Transgender Health (WPATH) developed Standards of Care (SOC) for Gender Identity Disorder describing the clinical approach for evaluation and treatment based on what the authors believed were the most current understanding of gender identity disorder. According to WPATH, under these standards, the clinical threshold for consideration of gender reassignment services occurs when concerns, uncertainties and questions about gender identity persist during a person's development and become so intense that they are the most important aspect of the person's life or prevent the establishment of a relatively unconflicted gender identity. According to WPATH, the SOC were based on the best available science and expert professional consensus. However, there is disagreement in the professional medical community regarding the extent to which the WPATH standards reflect the best available methodologically sound evidence.

WPATH SOC version 7 (2011). According to these standards of care, true transsexualism is identified as follows:

- A permanent and profound identification with the opposite sex

- A persistent feeling of discomfort regarding one's biological sex or feelings of inadequacy in the gender role of that sex
- The wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone replacement
- Clinically relevant distress and/or impaired ability to function in social, work-related and other situations
- Not a symptom of another mental disorder or a chromosomal abnormality
- Persistent presence of the transsexual identity for at least 2 years

Update 2016

The minimum age at which gender reassignment surgery is considered to be medically necessary is 18 years old for the following reasons: Gender reassignment surgery is a life-altering transformation that is irreversible, with profound physical and psychological changes. A substantial degree of developmental maturity is required in order to make a truly informed, educated decision to undergo such a transformation, and to understand all of the ramifications of such transformation including its irreversibility. Psychological and psychiatric studies have repeatedly shown that the developmental maturity that is required for such a decision is not attained until at least age 18 (Hembree 2011; Hembree, Cohen-Kettenis, Delemarre-van de Wall, et al 2009; Herbert 2011; Cohen-Kettenis P. Steensma TD. de Vries ALC 2011), and often later. Furthermore, brain imaging studies have more recently demonstrated that the brain does not structurally resemble an adult brain until the third decade of life. More specifically, the areas of the brain that regulate executive functions including planning, working memory, and impulse control (including the capacity to resist making impulsive decisions) do not mature until at least the early to mid-20s (Giedd JN 2004; Johnson SB. Blum RW. Giedd JN 2009; Sowell ER. Thompson PM. Holmes CJ 1999), and as late as age 30 in some individuals (Sowell ER. Thompson PM. Toga AW 2007). Accordingly, depending on the individual, adult developmental maturity is not attained until sometime between the early to mid-20s and age 30. Permitting major decisions such as gender reassignment surgery at age 18, which is the legal age of majority, can therefore be seen as more liberal than what science supports.

Although hormone therapy is common for adults prior to gender reassignment genital surgery, and is recommended by some clinicians and guidelines, the quality of evidence supporting pre-surgery hormone therapy for adults is very low (Hembree, Cohen-Kettenis, Gooren, et al 2017). There is no credible scientific evidence that pre-surgery hormone therapy for adults produces

greater improvement of gender dysphoria, greater satisfaction with the results of gender reassignment surgery, improved adjustment to new gender, or decreased emergence of post-gender reassignment surgery psychiatric symptoms or difficulties, than gender reassignment surgery without pre-surgery hormone therapy.

Potential adverse effects of estrogen therapy include deep vein thrombosis, thromboembolic disorders, increased blood pressure, weight gain, impaired glucose tolerance, liver abnormalities, and depression. Potential adverse effects of testosterone therapy include acne, edema secondary to sodium retention, and impaired liver function. (Becker, Perkins 2014)

Update 2021

Experts in the field have provided further elucidation of the content for letters of recommendation from mental health professionals that are most useful for surgeons and for health plans, and that provide improved clarity regarding patients' psychological preparedness for gender transition/affirmation surgery. (Etter 2018; Yarbrough 2018)

Coverage of non-breast/chest surgeries, non-genital surgeries, additional breast augmentation, and breast/chest or genital cosmetic procedures, for feminization or masculinization or non-binary transition, is mandated for state of Washington regulated health plans beginning in 2022. (Washington Senate Bill 5313, passed and signed into law in 2021)

The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) version 8 is pending release in late 2021, which may provide additional supporting evidence.

This policy has been reviewed by an internal psychiatrist.

Update 2023

Hormone therapy prior to augmentation mammoplasty (breast augmentation) was previously required based on studies that showed improved aesthetic outcomes according only to surgeons, not according to patients, which therefore did not address whether patients experienced a reduction in gender dysphoria that was more clinically significant with hormone therapy prior to augmentation mammoplasty. This requirement is no longer considered to be necessary based on two recent studies, which, although observational, not blinded, and with fewer patients (181 total between the two studies) than would have been optimal, have suggested a lack of significant clinical value from hormone therapy to grow breast tissue prior to

surgical breast augmentation for transgender women. One study showed that for transgender women, surgical breast augmentation significantly increased their self-perception of feminine gender identity more so than after hormone therapy but prior to surgery, and more so than the self-perception of a cohort of transgender women who had undergone only hormone therapy. The same study also showed that a cohort of other persons, who were a mix of cisgender, heterosexual, lesbian, gay, bisexual, and transgender persons, had a greater perception of transgender women who had undergone surgical breast augmentation as feminine compared to transgender women who had undergone only hormone therapy (Zhu, Callori, Boonipat, et al 2023). The other study showed that hormone therapy to grow breast tissue usually resulted in breast growth that was inadequate to achieve satisfactory feminine gender identity outcomes, but a majority of patients reported high satisfaction with outcomes following surgical breast augmentation, and all patients reported an improvement in their quality of life following, and which they attributed to, surgical breast augmentation (Schoffer, Bittner, Hess, et al 2022).

Uterine transplantation is considered investigational for gender transition/affirmation. Although supposedly successful uterine transplantation has been reported, challenges to successful uterine transplantation for gender transition/affirmation include small study populations, inability to complete transplants due to anatomical pelvic differences between natal females and natal males, transplant rejections, and increased risk of complications in transgender male donors due to the necessity of more extensive vaginal and ligamentous dissection compared to standard female-to-male hysterectomy. The existing literature acknowledges that uterine transplantation for transgender women is currently experimental and requires additional research before potentially being able to make the transition from research/investigational to established clinical care (Jones, Williams, Saso, et al 2019; Lerner, Ejzenberg, Pereyra, et al 2017; Balayla, Pounds, Lasry, et al 2021).

Penile transplantation (as distinct from penile prostheses) is considered investigational for gender transition/affirmation. The first penis transplant was reported in 2006, and a total of only five additional penis transplants have been reported worldwide subsequently (Lopez,, Girard, Lake, et al 2023; Lake, Girard, Lopez, et al 2022). All of these transplants were complicated by vascular congestion and/or hematoma that required surgical intervention, and all but one of the patients reported some degree of allograft tissue necrosis. All of these transplants were done for reasons other than gender transition/affirmation, specifically, because of catastrophic injury, irreversible vascular occlusion, or cancer, which resulted in penile loss. To date, there have been no reports of penile transplantation for gender transition/affirmation. Penile transplantation for gender transition/affirmation is considered to be theoretically possible, but actual feasibility has not been established (Lopez, Yusuf, Girard, et al 2023). Accordingly, there is no evidence to support penile transplantation for transgender males.

The minimum age at which gender transition/affirmation surgery is considered to be medically necessary continues to be 18 years old. Although there are advocates in the professional medical community for gender transition/affirmation surgery for adolescents, and reports and studies have been published which support gender transition/affirmation surgery for adolescents, primarily mastectomy, the studies have significant methodological shortcomings that negate the validity of their conclusions.

The most comprehensive and methodologically sound reviews of published studies have demonstrated that the evidence supporting gender transition/affirmation surgery for adolescents is weak to non-existent. Hayes Evolving Evidence Reviews of gender affirming surgical procedures for adolescents with gender dysphoria determined that the level of support (i.e., strength and quality of the evidence) for adolescent gender-affirming surgeries is minimal to non-existent based on review of full-text clinical studies, full-text systematic reviews, full-text clinical practice guidelines, and full-text position statements (Hayes May 12 2023; Hayes May 23 2023). Levine and Abbruzzese determined, based on systematic reviews of the evidence, that the research on youth gender transition is "deeply flawed," that the evidence "failed to show credible improvements in mental health and suggested a pattern of treatment-associated harms," and that the evidence "does not support the notion that 'affirmative care' of today's adolescents is net beneficial" (Levine, Abbruzzese 2023).

Levine and Abbruzzese also highlighted the fact that contrary to previous support for adolescent gender-affirming surgeries in several European countries, more recent "systematic reviews of evidence conducted by public health authorities in Finland, Sweden, and England concluded that the risk/benefit ratio of youth gender transition ranges from unknown to unfavorable" (Levine, Abbruzzese 2023). A report that was commissioned by the Swedish government to review the literature on gender dysphoria in children and adolescents found that "there are few studies on gender affirming surgery in general in children and adolescents and only single studies on gender affirming genital surgery," and "studies on long-term effects of gender affirming treatment in children and adolescents are few" (SBU Policy Support 2019). A review of the available research evidence prepared by the Council for Choices in Healthcare in Finland concluded that "in light of available evidence, gender reassignment of minors is an experimental practice," and "no irreversible treatment (i.e., surgery) should be initiated" for minors (Council for Choices in Healthcare in Finland 2020).

The World Professional Association for Transgender Health (WPATH) released version 8 of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People in September 2022. The Standards of Care include a chapter on gender affirming interventions for adolescents that supports gender transition/affirmation surgery for adolescents. However, in spite of supporting such surgery, the Standards of Care version 8 actually acknowledge that the

evidence supporting such surgery is weak and insufficient. The Standards of Care version 8 states the following with regards to gender affirming surgery in adolescents: "the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible" and "the existing samples reported on relatively small groups of youth" (conclusions based on small sample sizes are unreliable) and, "at present, no clinical cohort studies have reported on profiles of adolescents who regret their initial decision or detransition after irreversible affirming treatment." Recent research indicates there are adolescents who detransition" (the implication of the latter statement is that there is currently no reliable way to screen out those adolescents who might or will later regret having transitioned). Accordingly, although supporting gender transition/affirmation surgery for adolescents, the new/updated WPATH Standards of Care actually acknowledge that existing evidence does not support such surgery for adolescents (Coleman, Radix, Bouman, et al 2022).

This policy has been reviewed by an internal psychiatrist.

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History

Date	Comments
10/13/14	New policy, add to Surgery section. Gender reassignment services are covered when criteria are met.
11/24/14	Coding update. Code 19318 added to policy. No other changes.
01/13/15	Annual Review. Policy statement added. Surgery to reverse partially or fully completed gender reassignment is considered not medically necessary except in the case of a serious medical barrier to completing gender reassignment or the development of a serious medical condition necessitating reversal.
04/14/15	Clarification only. Added language to benefit application section and policy statement section regarding self-funded account benefit language. “Some self-funded groups may offer additional benefits in covering WPATH recommended surgeries and services. Refer to member contract language for benefit determination on coverage of gender reassignment surgery”.
05/27/15	Interim update. Added note in policy guidelines. The mental health evaluation and recommendation letters are required only at the beginning of the gender reassignment surgical process when it is spaced out over time. ICD-9 procedure codes 62.41, 65.61, 65.63, 68.41-68.49, 68.51 and 68.59 removed; ICD-10-PCS codes added per remediation effort.
09/02/15	Coding update. CPT codes 58570 and 58572 added to policy.
05/01/16	Annual Review, approved April 12, 2016. Criteria updated and age threshold added; 18 or over. Cosmetic services clarified.
05/24/16	Update Related Policies. Remove 7.01.548 as it is archived.
07/07/16	Coding update. Added CPT codes 19303, 19350, and 53430.
07/15/16	Coding update. Added CPT codes 19342 and 19357.
08/01/16	Coding update. Added CPT code 19304.

Date	Comments
08/12/16	Coding update: Remove CPT codes 58150, 58552, 58554, 58570, 58571, 58572, and 58573.
11/01/16	Interim Review, approved October 11, 2016. Language added in support the age application of this policy in support of non-discrimination mandate.
11/18/16	Policy moved to new format.
01/01/17	Interim Review, approved December 13, 2016. Added a note stating that any breast augmentation procedures after an initial augmentation mammaplasty are considered to be feminization or cosmetic procedures and therefore subject to member contract stipulations regarding such procedures.
03/01/17	Annual Review, approved February 14, 2017. Hair removal added as medically necessary to treat donor sites prior to phalloplasty or vaginoplasty. Added that preservation of fertility prior to surgery is considered not medically necessary unless there is another benefit which would cover this. Added that correction or repair of complications of gender altering surgery may be considered medically necessary for complications that cause significant discomfort or significant functional impairment, surgery to revise or to reverse and redo specific surgeries may be considered medically necessary when correction or repair of complications requires revision or undoing of the original surgery.
05/26/17	Correction was made to History section for the May 27, 2015, revision. Minor formatting edits were made.
10/01/17	Interim Review, approved September 12, 2017. Removed the requirement for meeting DSM diagnostic criteria and instead only requiring that an evaluating mental health professional confirm that the diagnosis applies.
03/01/18	Annual Review, approved February 27, 2018. Added "previously authorized" to clarify that correction or repair of complications may be medically necessary for previously authorized surgeries when criteria are met. Clarified that if the initial authorized gender reassignment surgery is not performed, then new mental health evaluation and recommendation letters are required if the original mental health evaluations and recommendation letters are more than six months. Updated references.
06/19/18	Added Site of Service information to the policy.
07/01/18	Removed Site of Service information from the policy, removed CPT code 19318.
10/05/18	Minor update. Added Documentation Requirements section.
03/01/19	Annual Review, approved February 25, 2019. No changes to policy statements.
10/25/19	Minor update. Hysterectomy was removed from list of services; it was inadvertently left when the CPT code was removed from policy.
01/01/20	Coding update, adding note that CPT code 19304 terminated effective 1/1/20.
10/01/20	Annual Review, approved September 1, 2020. No changes to policy statements.

Date	Comments
08/01/21	Annual Review, approved July 22, 2021. No changes to policy statements. Removed termed CPT code 19304.
10/01/21	Coding update, Added CPT code 57335.
01/01/22	Interim Review, approved December 14, 2021. Major update, including: title change from Gender Reassignment Surgery to Gender Transition/Affirmation Surgery; terminology change; clarification of ancillary procedures that can be covered in conjunction with covered surgeries; clarification of the requirement for a pre-surgery evaluation by the surgeon; addition of new criteria for previously-labeled "cosmetic" procedures in order to comply with Washington Senate Bill 5313 and for self-funded plans emulating Washington Senate Bill 5313; identification of separate criteria for hair removal prior to genital surgery; clarification of details required for content of mental health recommendation letters; clarification of time limits before new mental health recommendation letters are required; clarification of coverage and of requirement for mental health recommendation letters when previous gender transition/affirmation surgery was not done under a Company plan. Added CPT codes 11920, 11921, 11922, 11950, 11951, 11952, 11954, 11960, 15775, 15776, 15780, 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, 15839, 15847, 15876, 15877, 15878, 15879, 17380, 17999, 19318, 21087, 21120, 21121, 21122, 21123, 21125, 21127, 21138, 21139, 21208, 21209, 21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450, 31599, 31899, 40500, 40510, 40520, 40525, 40527, 54400, 54401, 54405, 58150, 58552, 58554, 58570, 58571, 58572, 58573. Added HCPCS codes C1813 and C2622.
02/01/22	Minor editing, formatting only. Converted bullet formatting to policy table "Services" in some areas that were previously listed in parenthetical form. No change in content or intent.
02/18/22	Minor edit for clarification only. Added Company plan to Definition of Terms section. Changed "then" to "and" on the last bullet criterion within revisions and corrections sections located in the Expanded Coverage section. No other changes.
04/01/22	Coding update. Added CPT codes 15771, 15772, 15773, and 15774.
06/01/22	Coding update. Corrected CPT code 15571 to 15771.
06/22/22	Correction was made to the policy statement on preservation of fertility to indicate that such procedures may be considered medically necessary as part of gender transition/affirmation services "except for those plans which do not include a benefit for assisted reproduction." This was an error; the statement previously mistakenly appeared as "…plans that include…" and doesn't change the intent of the policy.
07/01/22	Annual Review, approved June 14, 2022. Policy title changed from Gender Transition/Affirmation Surgery to Gender Transition/Affirmation Surgery and Related Services. For mental health recommendation letters, changed "psychotherapy monthly or more frequently" to "psychotherapy or mental health treatment" without the frequency requirement. For the surgeon's pre-surgery evaluation, added no

Date	Comments
	documentation of any necessary medical evaluations or treatment or clearance prior to surgery, or of any healthcare action that is necessary prior to surgery. Added a Note that mastectomy or additional breast reduction after initial breast reduction surgery is considered to be a new procedure, not the second stage of breast/chest surgery or revision of the initial surgery. Added a note that if hormone treatment has resulted in breast growth greater than a young adolescent stage of development, then initial male to female augmentation mammoplasty can be considered for coverage as a feminization procedure if the member's plan has coverage for such procedures. For expanded benefit coverage, corrected the criteria for mental health recommendation letters and for pre-surgery evaluations by the surgeon to cover both prospective and retrospective requests. Clarified that for hair removal, which is not surgery, the pre-procedure evaluation is by a referring medical provider or the hair removal provider. Added "if the complication is causing or is likely to cause a medical or surgical emergency" for correcting complications of surgery that was done under a non-Company plan. Added criteria for when MH recommendations could be from clinicians who are not licensed to practice independently and deleted a criteria point that letters written by trainees or by clinicians requiring supervision and co-signed by supervising clinicians are not acceptable. Added meeting DSM criteria for Gender Dysphoria as an alternative for documenting current gender dysphoria symptoms. Added a criterion for the MH recommendation letters that if psychiatric medication is being taken for treatment of any psychiatric symptoms or disorders, the letters must verify or demonstrate that such symptoms or disorders are reasonably well-controlled and are not contraindications to surgery. Added requirements for updated or new pre-surgery surgeon evaluations when authorized surgery is not done within six months, or when significantly different procedures are spaced-out over time. Added a statement regarding documentation that a general statement that WPATH criteria or standards are met is not sufficient. Removed CPT code 11960.
09/01/22	Interim Review, approved August 22, 2022. Updates made to the criteria for when MH recommendations can from clinicians who are not licensed to practice independently, added limited license as indicating a type of clinician not licensed to practice independently. Also, in the criteria for when MH recommendations can be from clinicians who are not licensed to practice independently, added an option for the co-signing licensed mental health professional to be present during the clinician's evaluation of the patient. Added documentation of full DSM criteria for Gender Dysphoria as an alternative to documenting persistence of gender dysphoria over time. Modified the alternative to documenting current gender dysphoria symptoms to documentation of full DSM criteria for Gender Dysphoria. Modified the two-year time period during which mental health recommendation letters are required only at the beginning of the gender transition/affirmation surgical process to two years from the date of the initial surgery authorization. Added a missing journal article citation in the References section.
11/01/22	Interim Review, approved October 27, 2022. Added hysterectomy to the list of genital surgeries. Removed the note that hysterectomies for gender transition/affirmation are not subject to medical necessity review. Clarified that hair removal under the expanded

Date	Comments
	benefit is facial, body, and extremity hair removal not related to genital surgery. For hair removal related to genital surgery, and for facial, body, and extremity hair removal, added clarification that hair removal can be done by a physician, nurse practitioner, physician assistant, or by a professional who is licensed, certified, registered, or otherwise approved by the state for hair removal (e.g., a licensed aesthetician). Reorganized the expanded benefit coverage section so that there is a distinct subsection for facial, body, and extremity hair removal. Added "additional timing requirements for surgery and mental health recommendation letters, and for pre-surgery surgeon evaluations" to the section title of "Recommendations by Licensed Mental Health Professionals." Removed the requirement for psychiatrists to be board eligible or board certified because it is not practical to research that, and there is no similar requirement for any of the other types of mental health professionals. Simplified the requirement for co-signing by master's degree level or doctoral level mental health professionals who are state licensed to practice independently, of letters of recommendation written by state licensed master's and doctoral level mental health clinicians who are not licensed to practice independently, based on extensive feedback that co-signing indicates that the cases and letters were reviewed and approved by the mental health professionals who are state licensed to practice independently. Clarified that pre-procedure evaluations by either a referring medical provider or the hair removal provider are acceptable as the pre-surgery surgeon evaluations for facial, body, or extremity hair removal not related to genital surgery. Reorganized and reworded some of the content requirements for mental health recommendation letters for improved clarity and to eliminate redundancies. Replaced two previous mental health recommendation letter requirements with a requirement for a history of the member's gender dysphoria and gender identity transition. Added site of service is subject to medical necessity review for the following surgical procedures that are addressed in this policy: breast reduction, laparoscopic-assisted vaginal hysterectomy, rhinoplasty, and vaginal hysterectomy. Added CPT codes 58260, 58262, 58290, 58291. Policy changes are effective February 3, 2023, following a 90-day provider notification.
01/01/23	Interim Review, approved December 13, 2022. Removed the designations of Standard Benefit and Expanded Benefit because all services covered in this policy are now considered to comprise the standard benefit for all plans, with the exception of certain employer sponsored group plans that have different benefits or exclude coverage of some gender transition/affirmation services.
10/01/23	Annual Review, approved September 12, 2023. Minor verbiage modifications made in various places throughout the document. Changed "member" to "individual" throughout the document except for "member contract." Modified the statement that most plans cover additional gender transition/affirmation surgeries for feminization, masculinization, or transition to non-binary, to, many plans (instead of most plans). Added: "Please refer to the member contract language or call customer service to determine what coverage the individual's plan has." Clarified that some plans exclude coverage of some or all (instead of just some) gender transition/affirmation services. Moved all Notes to a new "Additional Information" section.

Date	Comments
	For surgery or procedures that require a mental health recommendation: Clarified that mental health recommendations can be recommendations or support for surgery, and can be via letters or medical record documentation; Changed the time requirement for mental health recommendation/support from 6 months prior to the request to 12 months prior to the request (to be consistent with the increase in the time period of authorization from 6 months to 12 months). Changed the requirement for mental health recommendation/support for genital surgery from two (two letters or medical record documentation) to one. For all surgery and procedures, removed the requirement for a pre-surgery or pre-procedure surgeon's or other provider's evaluation. For Augmentation mammoplasty: Removed the requirement for hormone therapy and removed related Notes; Added notes in the new Additional Information section that a trial of hormone therapy is not a pre-requisite for qualifying for augmentation mammoplasty, and that augmentation mammoplasty may be done via implants or fat transfer or a combination of both. With the removal of the requirement for hormone therapy for augmentation mammoplasty, combined the two sections for Mastectomy or breast reduction and Augmentation mammoplasty into one section; Clarified "Initial" Augmentation mammoplasty/breast augmentation in the section title. In the section title of the Genital surgery section, for penile prostheses, deleted "(for health plans which cover those for gender transition/affirmation)." because these are covered unless specifically excluded for all conditions. For Hair removal related to genital surgery: Changed the diagnosis requirement to "Genital surgery for gender affirmation has been authorized under a Company plan within the last 12 months" as an alternative to c, or, Confirmation of the diagnosis of Gender Dysphoria; , and verification (via statement or a listing of the individual's criteria that are met) that all diagnostic criteria for Gender Dysphoria are met as specified in the current version of DSM, by a physician, nurse practitioner, or licensed mental health professional; Added a requirement for documentation that hair removal will be from existing genital sites where surgery will be performed or from donor tissue that will be utilized to form female or male genitals; Expanded the types of approved hair removal providers to a physician, nurse practitioner, physician assistant, or a professional who is licensed, certified, registered, or otherwise approved by the state for hair removal (e.g., a licensed or certified esthetician or aesthetician, electrologist, medical esthetician or aesthetician, or medical electrologist), or at a clinic or so-called spa that is state licensed, certified, or approved for hair removal; Added a Note in the new Additional Information section that when hair removal is done at so-called spas, the professional or professionals doing the hair removal must be one of the provider types noted above unless the spa is state licensed or certified or approved for hair removal. Added a Note in the new Additional Information section that a mental health recommendation is not required for hair removal, and that a pre-procedure evaluation by the hair removal provider or referring medical provider is not required for hair removal.

Date	Comments
	For Additional breast augmentation, and breast/chest or genital cosmetic procedures, for feminization or masculinization or non-binary transition (previously referred to as "cosmetic" surgeries or procedures), Non-breast/chest surgeries or procedures, Non-genital surgeries or procedures, and Hair transplantation/grafting: Consolidated three criteria into one and removed some redundancies; For criteria re: procedures not related to feminization/masculinization/non-binary transition, added "there is no documentation of" (so that in the absence of any such documentation, these criteria are satisfied);Combined three bullet point items into one, removed some redundancy, and added "there is no documentation of" to criteria where appropriate to address procedures not related to feminization/masculinization/non-binary transition; Changed "not being pursued for enhancing features which are already clearly recognizable as feminine, masculine, or non-binary" to "not being pursued for significantly enhancing or exaggerating features which are already clearly recognizable as feminine, masculine, or non-binary (e.g., to achieve appearance comparable to certain celebrities).;" Separated Facial or body or extremity hair removal not related to genital surgery, and Medical tattooing, into separate sections. For facial or body or extremity hair removal not related to genital surgery: For clarification, added (by laser or electrolysis) to the section title; Removed the requirement for a mental health recommendation; In lieu of a mental health recommendation, substituted Changed the diagnosis requirement to "Genital surgery for gender affirmation has been authorized under a Company plan within the last 12 months, or, Confirmation of the diagnosis of Gender Dysphoria, and verification (via statement or a listing of the individual's criteria that are met) that all diagnostic criteria for Gender Dysphoria are met as specified in the current version of DSM, by a physician, nurse practitioner, or licensed mental health professional.;" Consolidated three criteria into one and removed some redundancies; For criteria re: procedures not related to feminization/masculinization/non-binary transition, added "there is no documentation of" (so that in the absence of any such documentation, these criteria are satisfied);Combined hree bullet point items into one, removed some redundancy, and added "there is no documentation of" to criteria where appropriate to address procedures not related to feminization or non-binary transition; Added a requirement for documentation that hair removal is intended to reduce the individual's gender dysphoria; Added a requirement for documentation of the body area or areas from which hair will be removed; Changed "not Changed "not being pursued for enhancing features which are already clearly recognizable as feminine or non-binary" to "not being pursued for significantly enhancing or exaggerating features which are already clearly recognizable as feminine or non-binary (e.g., to achieve appearance comparable to certain celebrities);" Expanded the types of approved hair removal providers to a physician, nurse practitioner, physician assistant, or a professional who is licensed, certified, registered, or otherwise approved by the state for hair removal (e.g., a licensed or certified esthetician or aesthetician, electrologist, medical esthetician or aesthetician, or medical electrologist), or at a clinic or so-called spa that is state licensed, certified, or approved for hair removal; As noted above, added a Note in the

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	new Additional Information section that when hair removal is done at so-called spas, the professional or professionals doing the hair removal must be one of the provider types noted above unless the spa is state licensed or certified or approved for hair removal; As noted above, added a Note in the new Additional Information section that a mental health recommendation is not required for hair removal (removed this requirement), and that a pre-procedure evaluation by the hair removal provider or referring medical provider is not required for hair removal (removed this requirement). Removed a separate stand-alone comment about retrospective requests regarding mental health recommendations for about retrospective requests due to redundancy with previous comments and placement in a location that could have inadvertently been misread as applying to medical tattooing. For clarification, added new sections specifically for Uterine transplantation and Penile Transplantation, stating that they are considered investigational for gender transition/affirmation (they have not previously been recognized for gender transition/affirmation under this policy). For Revision of appearance: Added "or the previous surgery resulted in a significant deformity that is not a component of normal anatomy (e.g., dog ears after mastectomy or symmastia after breast augmentation); Added "there is no documentation" to the second bullet point item; Somewhat streamlined the third bullet point item. For Reversal, added "(which may include restoring anatomic features of the gender that was assigned at birth). For Correction of complications, added: "or a serious medical or surgical condition (e.g., potential complications of wound dehiscence)." For Revision of appearance, Incomplete or incorrectly done surgeries, Reversal, and Correction of complications, added for clarification "(there is documentation which shows that criteria for the previous surgery were met at the time of that surgery)." Separated Recommendations by Licensed Mental Health Professionals and Additional timing requirements for mental health recommendations into two separate sections. Renamed the timing section title to: Additional timing requirements for mental health recommendations (deleted "for surgery" and "for pre-surgery surgeon evaluations" and "letters"). For Recommendations by Licensed Mental Health Professionals: Added that evaluations or psychotherapy or mental health treatment may be in-person or virtual; Corrected "Evaluations or qualifying psychotherapy" to "Evaluations or psychotherapy or mental health treatment: For a recommendation supporting the member's desire to proceed with the specific gender transition/affirmation surgery that is proposed, added "or with gender transition/affirmation surgery in general;" Clarified that a date or dates within the previous 12 months when the mental health professional most recently evaluated or treated the member must be specified, and added a Note about this in the new Additional Information section; For DSM diagnostic criteria for Gender Dysphoria, clarified that this can be via verification (via a statement) or demonstration

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	(via a listing or demonstration of the individual's criteria); deleted "or Gender Identity Disorder;" Modified the history requirement to "A summary of the individual's gender incongruence and gender identity transition including at a minimum: when the individual became aware of, or how long the individual has been aware of, gender incongruence; verification or demonstration of persistence of gender incongruence or gender dysphoria over time; verification or demonstration of persistence over time of the desire to transition to the desired gender identity; actions taken, if any, to transition to, or live or function as, the desired gender identity;" For verification or demonstration that the individual's decision to have the surgery is not due to any mental disorder or mental health concern other than gender dysphoria, added an option for documentation that there is no evidence of any other mental disorder or mental health concern other than gender dysphoria; For any mental disorders or mental health concerns other than gender dysphoria that are reported or identified, clarified that this includes depression or anxiety that are not symptoms of or due to gender dysphoria; For no comorbid mental health disorders or concerns, added "or documentation that there is no evidence of or any other mental disorders or concerns other than gender dysphoria;" Added for clarification (a subset of no comorbid mental health disorders or concerns) "If depression or anxiety are specifically reported or identified, verification that they are symptoms of gender dysphoria and are not symptoms of any other mental disorder; alternately, if depression or anxiety are symptoms of any other mental disorders, including but not limited to depressive disorders or anxiety disorders, verification or demonstration that such disorders or concerns are reasonably well-controlled, are not influencing the decision to proceed with surgery, and are not contraindications to surgery;" Removed "Any current or past psychiatric treatment (including for gender dysphoria) or substance use treatment, if any (not required if there has been no such treatment);" Removed "If psychiatric medication is being taken for treatment of any psychiatric symptoms or disorders, verification or demonstration that such symptoms or disorders are reasonably well-controlled and are not contraindications to surgery" due to the widespread use of psychiatric medications for non-psychiatric conditions and the frequent absence of documentation of the reason for a psychiatric medication." For Additional timing requirements for mental health recommendations: Increased the timeframe before an updated or new mental health recommendation is needed if authorized surgery is not done from 6 months after authorization to 12 months after authorization; Reduced the number of elements that are required for an updated or new mental health recommendation in that situation; Reworded the section (for better clarity and to account for only one mental health recommendation being needed for genital surgery); Added Notes in the new Additional Information section that additional timing requirements apply for all surgery or procedures that require mental health recommendations, and that for plans that use WPATH standards as customized criteria, additional timing requirements are not applicable for WPATH standards; all WPATH criteria must be met with each requested surgery or procedure

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	Added additional Notes in the new Additional Information section: For all surgery and procedures: Authorizations for all surgery and procedures are valid for 12 months from the date of authorization. A new authorization must be requested for any authorized surgery or procedure that is not done or completed within twelve months of the date when it was authorized. For all surgery and procedures: All requirements must be met for each new request for coverage of surgery or a procedure, with the possible exception of mental health recommendations for surgery or procedures for which coverage is requested within two years of the date when the first authorized gender transition/affirmation surgery or procedure was authorized – see the section Additional timing requirements for mental health recommendations above. Hormone treatment is not a pre-requisite for genital surgery Penile prostheses are covered for gender transition/affirmation unless a plan has a specific exclusion for penile prostheses for all conditions. An exclusion for penile prostheses for sexual dysfunctions does not apply to gender transition/affirmation because gender dysphoria is not a sexual dysfunction. If the body area or areas from which hair will be removed are not specified, then it is assumed that the hair removal is facial and/or body and/or extremity hair removal, not hair removal prior to genital surgery. CT imaging for pre-surgery planning is considered to be medically necessary when facial feminization or masculinization surgery is determined to be medically necessary Revisions are considered not medically necessary when the original surgery was determined to be not medically necessary. Correction of incomplete or incorrectly done surgery is considered not medically necessary when the original surgery was determined to be not medically necessary. Correction or Repair of Complications/Revision or Reversal Due to Complications are considered not medically necessary when the original surgery was determined to be not medically necessary except when an emergency or potential emergency. If member contract terms for coverage of complications of surgery differ from the criteria above, then the member contract terms determine coverage (e.g., complications are covered under the same conditions as complications of other services or surgery). Reversal is considered not medically necessary when the original surgery was determined to be not medically necessary. Revisions, Correction of incomplete or incorrectly done surgery, Correction or Repair of Complications/Revision or Reversal Due to Complications, Reversal: Some self-funded group plans (group plans that are subject to ERISA – the Federal Employee Retirement Income Security Act of 1974) may cover surgery for these (above) done when the member was not on the group's health plan regardless of

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	whether the previous surgery would have been covered if the member had been on the plan at that time; refer to member contract language for those groups. Unlike physicians and nurse practitioners, physician assistants are not certified in specialties. Physician assistant specialties are determined by the specialty setting in which they are working. Psychiatric physician assistants are therefore physician assistants who are working in a psychiatric setting. The date that a letter or medical record documentation was written does not by itself show that the mental health professional actually evaluated or treated the individual on that date. The letter or medical record documentation must therefore specify the date or dates within the previous 12 months when the mental health professional most recently evaluated or treated the individual. In the Documentation Requirements section: Modified the statement that a general statement that WPATH criteria or standards are met is not sufficient (to eliminate confusion that WPATH criteria have to be specified); Modified several items in order to be consist with modifications to criteria. Revised the Benefit Application section to reflect the fact that surgical benefits for AK plans are not expanding beyond top and bottom surgery. In the Evidence Review section, modified one of the initial paragraphs about WPATH standards that inadvertently implied that WPATH standards were based on sound evidence, to more correctly note that the WPATH standards were based on sound evidence according to WPATH, but that there was disagreement about that in the professional medical community. Added Update 2023 to address the removal of the requirement for hormone therapy to grow breast tissue prior to augmentation mammoplasty/surgical breast augmentation, the lack of evidence for uterine and penile transplants, and the lack of evidence for gender transition/affirmation surgery for adolescents. Added 14 references cited in and supporting Update 2023.
03/01/24	Interim Review, approved February 13, 2024. For surgeries other than breast/chest and genital surgery, breast augmentation after initial breast augmentation, facial or body or extremity hair removal, and medical tattooing, combined and condensed into a single criterion the two criteria regarding there being no reason for the surgery or procedure other than gender affirmation. For hair removal related to genital surgery, modified the criterion for a diagnosis of gender dysphoria to be consistent with the criterion for a diagnosis of gender dysphoria for facial or body or extremity hair removal not related to genital surgery. For facial or body or extremity hair removal not related to genital surgery, clarified in the section title and in an added comment that facial or body or extremity hair removal not related to genital surgery is for feminization or non-binary transition only, it is not for masculinization. Added a comment that hair removal is presumed to be facial or body or extremity hair removal if the location of hair removal is not specified. Clarified that for recommendations by licensed mental health professionals, a summary of the individual's gender

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	incongruence and gender identity transition is intended to be a summary of the history of the individual's gender incongruence and gender identity transition.
08/01/24	Annual Review, approved July 22, 2024. For revision, correction of incomplete or incorrectly done surgery, and correction or repair of complications, replaced the requirement that if the previous surgery was done when the individual was not covered by a Company plan, the previous surgery would have been covered if the individual was on a Company plan at the time of that surgery, with the stipulation "Coverage for the original gender transition/affirmation surgery is available under the individual's current health benefit plan." For mental health recommendations, added clarification that for the option of having lived in the gender role appropriate for the desired gender for the immediately preceding 12 months, the individual must have lived full-time in the gender role appropriate for the desired gender identity.
10/01/24	Interim Review, approved September 23, 2024. Clarified that hair removal will be done in a clinic or office setting, outside of a hospital. Added CPE (Certified Professional Electrologist) to the types of providers that can be approved for hair removal because some states do not license or certify hair removal providers. Moved the statements that revision of appearance, correction of incomplete or incorrectly done surgery, and correction or repair of complications are considered not medically necessary when the original surgery was determined to be not medically necessary from the Additional information section to the respective criteria sections, as Notes; added an exception for when a complication is causing or is likely to cause a medical or surgical emergency. For showing that a mental health recommendation is based on an evaluation or treatment within the past 12 months, added the option of a frequency of evaluation or treatment sessions which demonstrates that the individual was evaluated or treated within the past 12 months. Provided additional clarification that the two-year period when another mental health recommendation is not required is two years from the date of authorization of the first surgery or procedure that required a mental health recommendation, even if additional surgeries or procedures that require a mental health recommendation are authorized during the two-year period.
11/01/24	Interim Review, approved October 21, 2024. For revision of appearance after previous gender transition/affirmation surgery, for the option of previous surgery having resulted in a significant deformity that is not a component of normal anatomy, clarified that the deformity is verified on a physical examination. For reversal of partially or fully completed gender transition/affirmation surgery, added exceptions for (1) if the original surgery was done when the individual was not covered by a Company plan, coverage of the original surgery is available under the individual's current health benefit plan, and (2) if the original surgery was determined to be not medically necessary, a complication is causing or is likely to cause a medical or surgical emergency – to be consistent with the same exceptions for revision of appearance, correction of incomplete or incorrectly done surgery, and correction or repair of complications.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.