MEDICAL POLICY – 7.01.557
Gender Reassignment Surgery

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Introduction

Gender reassignment is the process of changing the gender characteristics a person was born with to the gender characteristics a person identifies with. Gender reassignment surgery is one of the last steps in this process. This surgery changes sexual characteristics - the genitals and breasts - 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 and surgery. This policy describes the procedures that are covered as part of gender reassignment 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

Note: 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.
Except when otherwise stipulated in member contract language, gender reassignment surgeries are considered to be medically necessary as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Criteria</th>
</tr>
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</table>
| Mastectomy for female to male patients and augmentation mammaplasty for male to female patients | - One comprehensive evaluation and recommendation within the last six months from a licensed mental health professional (see Guidelines below) AND  
- Diagnosis of gender dysphoria (formerly gender identity disorder) confirmed by the evaluating mental health professional AND  
- 18 years of age or older AND  
- No medical contraindications to surgery  

Note: A trial of hormone therapy is not a pre-requisite for qualifying for a mastectomy.  

- For augmentation mammaplasty for male to female patients, one of the following:  
  - failure of breast growth stimulation by estrogen (progression only to a young adolescent stage of development)  
  - emergence of serious or intolerable adverse effects during estrogen administration  
  - medical contraindication to use of estrogen  
  - risk-benefit analysis determined that surgery is preferable to estrogen therapy  

Note: The criteria above apply for initial male to female augmentation mammaplasty. Additional breast augmentation after an initial augmentation mammaplasty is considered to be a feminization or cosmetic procedure, and therefore, member contract stipulations for
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Criteria</th>
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<tbody>
<tr>
<td></td>
<td>feminization or cosmetic procedures (either contract exclusion or coverage criteria, whichever is applicable for the member’s health plan) apply.</td>
</tr>
<tr>
<td><strong>Hysterectomy, salpingo-oophorectomy in female to male, orchiectomy in male to female, metoidioplasty, phalloplasty, vaginectomy, scrotoplasty, urethroplasty, placement of testicular prostheses, in female to male patients, and for vaginoplasty, clitoroplasty, labiaplasty, penectomy in male to female patients:</strong></td>
<td>1. Two separate comprehensive evaluations and recommendations within the last six months from two separate licensed mental health professionals (see <strong>Guidelines</strong> below) <strong>AND</strong> 2. Diagnosis of gender dysphoria (formerly gender identity disorder) confirmed by one of the evaluating mental health professionals <strong>AND</strong> 3. No medical contraindications to surgery <strong>AND</strong> 4. 18 years of age or older</td>
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</tbody>
</table>
| **Surgeries primarily for feminization or masculinization** | **Surgeries primarily for feminization or masculinization are considered cosmetic, and therefore are excluded from coverage on most contracts. These services are performed for the purpose of improving or altering appearance or self-esteem, and do not improve functional status.**  
**Surgeries considered cosmetic include but are not limited to the following:**  
- Rhinoplasty or nose implants  
- Face-lifts  
- Lip enhancement or reduction  
- Facial bone reduction or enhancement  
- Blepharoplasty  
- Breast augmentation  
- Liposuction of the waist (body contouring)  
- Reduction thyroid chondroplasty  
- Hair removal  
- Voice modification surgery (laryngoplasty or shortening of the vocal cords)  
- Skin resurfacing  
**Note:** Exception: Hair removal procedures (including electrolysis) may be |
### Service | Coverage Criteria
--- | ---
Preservation of fertility | Procedures for preservation of fertility, eg, procurement, cryopreservation, and storage of sperm, oocytes, or embryos, performed prior to gender reassignment surgery, are considered to be not medically necessary.
Reversal | 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.
Revision | Surgery to revise the appearance of previous gender change surgery because of dissatisfaction with the outcome is considered to be cosmetic, not an inherent component of the gender change process, and not an untoward complication, and is therefore considered to be not medically necessary.
Correction or repair of complications | Surgery to correct or repair complications of gender altering genital or breast/chest 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 gender altering genital or breast/chest procedures, may be considered medically necessary when correction or repair of complications requires revision or undoing of the original genital or breast/chest procedure. (Example: Baker IV contracture after breast augmentation necessitates removal of the implants, and replacement with smaller implants.)

### Guidelines | Coverage Criteria
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Licensed Mental Health Professional | Evaluations and recommendations must be performed by professionals who are licensed by the state in which they provide services as Master’s level mental health clinicians, doctoral level mental health clinicians, psychiatric nurse practitioners, or physicians (in which case they must also be Board-Eligible or Board-Certified in psychiatry). When two
Guidelines | Coverage Criteria
--- | ---
evaluations are required, at least one must be by a doctoral level mental health provider (MD or DO psychiatrist, PhD or PsyD clinical psychologist).
The required minimum content of the mental health evaluation and recommendation is as follows:
- Confirmation of the diagnosis of gender dysphoria or gender identity disorder
- A recommendation supporting or not supporting the member’s desire to proceed with gender reassignment surgery and the rationale for the recommendation
- If the recommendation supports proceeding with surgery, an assessment of the member’s capacity to make a fully informed decision about proceeding with the surgery
- If the recommendation supports proceeding with surgery, identification of any co-morbid psychiatric disorders or other mental health concerns with documentation that those are not influencing the individual’s decision regarding surgery, are not contraindications to surgery, and are not likely to cause a negative psychiatric outcome after the surgery
- If the recommendation supports proceeding with surgery, verification that the member’s decision is current, is well thought out, is not impulsive, and is not the product of any other potentially treatable mental disorder

Note: 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. However, if a mastectomy or augmentation mammoplasty is the first surgical procedure, then a second mental health evaluation and recommendation letter is required prior to genital surgery.

Guidelines | Informational
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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)
• 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

**Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
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<td>Description</td>
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<td>19304</td>
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<td>19318</td>
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<td>19325</td>
<td>Mammaplasty, augmentation; with prosthetic implant</td>
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<td>19342</td>
<td>Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
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<td>19350</td>
<td>Nipple/areola reconstruction</td>
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<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
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<td>53430</td>
<td>Urethroplasty, reconstruction of female urethra</td>
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<td>Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach</td>
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<td>55980</td>
<td>Intersex surgery; female to male</td>
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<td>56625</td>
<td>Vulvectomy, simple; complete</td>
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<td>56800</td>
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<td>Revision (including removal) of prosthetic vaginal graft; vaginal approach</td>
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**ICD-10-PCS**

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<td>Creation of Penis in Female Perineum, Open Approach</td>
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</tbody>
</table>

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).
**Definition of Terms**

**Cosmetic:** In this policy, cosmetic services are those which are primarily intended to preserve or improve appearance. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient’s appearance or self-esteem.

**Gender:** This term refers to the perception of a person’s sex on the part of society as male or female.¹

**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

**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**

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.

**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

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 the most current understanding of gender identity disorder. 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. The SOC are based on the best available science and expert professional consensus.

WPATH SOC (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 can therefore be seen as more liberal than what science supports, consistent with culture more than with science.

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, Delemarre-van de Wall, et al 2009). 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)

This policy has been reviewed by an internal psychiatrist.
References


History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>10/13/14</td>
<td>New policy, add to Surgery section. Gender reassignment services are covered when criteria are met.</td>
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<td>Comments</td>
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<td>11/24/14</td>
<td>Coding update. Code 19318 added to policy. No other changes.</td>
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<td>01/13/15</td>
<td>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.</td>
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<td>04/14/15</td>
<td>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”.</td>
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<td>05/27/15</td>
<td>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.</td>
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<tr>
<td>09/02/15</td>
<td>Coding update. CPT codes 58570 and 58572 added to policy.</td>
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<tr>
<td>05/01/16</td>
<td>Annual Review, approved April 12, 2016. Criteria updated and age threshold added; 18 or over. Cosmetic services clarified.</td>
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<tr>
<td>05/24/16</td>
<td>Update Related Policies. Remove 7.01.548 as it is archived.</td>
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<tr>
<td>07/07/16</td>
<td>Coding update. Added CPT codes 19303, 19350, and 53430.</td>
</tr>
<tr>
<td>07/15/16</td>
<td>Coding update. Added CPT codes 19342 and 19357.</td>
</tr>
<tr>
<td>08/01/16</td>
<td>Coding update. Added CPT code 19304.</td>
</tr>
<tr>
<td>08/12/16</td>
<td>Coding update: Remove CPT codes 58150, 58552, 58554, 58570, 58571, 58572, and 58573.</td>
</tr>
<tr>
<td>11/01/16</td>
<td>Interim Review, approved October 11, 2016. Language added in support the age application of this policy in support of non-discrimination mandate.</td>
</tr>
<tr>
<td>11/18/16</td>
<td>Policy moved to new format.</td>
</tr>
<tr>
<td>01/01/17</td>
<td>Interim Review, approved December 13, 2016. Added a note stating that any breast augmentation procedures after an initial augmentation mammoplasty are considered to be feminization or cosmetic procedures and therefore subject to member contract stipulations regarding such procedures.</td>
</tr>
<tr>
<td>03/01/17</td>
<td>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</td>
</tr>
</tbody>
</table>
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.

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. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2017 Premera All Rights Reserved.

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.
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5952. TTY 800-840-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room S90F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.

Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Amharic):

لا يوجد هنا تحديد تاريفية مهمة.

Arabic (Cushite):

تاريفية هامة توجد هنا.

Arabic (Arabic):

يوجد هنا تحديد تاريفية مهمة.

Arabic (Chinese):

本通知有重要的讯息。本通知可能有关於您透过 Premera Blue Cross 提交的申请或保险的重要讯息。本通知内可能有重要日期。您可能需要在截止日期之前采取行动，以保留您的健康保证或费用补贴。您有权利免费以您的母语得到本讯息和帮助。请拨电话 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):

Beekisi kuni odeeafanno baa*bachababaa qaa ba*.

Italian (Italian):

Premera Blue Cross

Korean

본 통지서는 중요한 정보가 든습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross를 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에는 놀랍게도 납부를 할 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 적금을 절약하기 위해서 일정한 만감까지 조기를 취할 필요가 있을 수 있습니다. 귀하의 건강 커버리지에 어떤 비용 부담없이 없을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357)로 전화하시십시오.

Laos

ຊັກລາວນີ້ສາມາດຮັບຂໍ້ມູນຍາງສຸດທ້າຍໄດ້. ແລະເຮືອບການນີ້ຮ້ອງສະຫະຍານກ່ຽວກັບຄວາມຊ່ວຍເຫຼືອງ.

Lao

uintptr(0x7fc9757dd3d0) dump:

Romanian


Russian

Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Spanish

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog


Thai

ประกาศนี้มีข้อมูลสําคัญ ให้ท่านทราบเรื่องการขอความช่วยเหลือของคุณผ่าน Premera Blue Cross หรือการพบปะกับ Premera Blue Cross. มีข้อมูลสําคัญเกี่ยวกับการขอความช่วยเหลือของคุณผ่าน Premera Blue Cross หรือการพบปะกับ Premera Blue Cross. ท่านสามารถติดต่อทีมสนับสนุนเริ่มต้นการขอความช่วยเหลือที่ท่านต้องการได้ที่ 800-722-1471 (TTY: 800-842-5357).

Vietnamese


Український

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує можливість того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Ваший рідній мові. Дозвіться за номером телефону 800-722-1471 (TTY: 800-842-5357).