

## Corporate Medical Policy

### Gender Affirmation Surgery

**File Name:** gender\_affirmation\_surgery  
**Origination:** 7/2011  
**Last Review:** 9/2023

#### Description of Procedure or Service

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Gender Dysphoria (GD) is the formal diagnosis used by professionals to describe persons who experience significant gender dysphoria (discontent with their biological sex and/or birth gender). Although it is a psychiatric classification, GD is not medically classified as a mental illness.

In the U.S., the American Psychiatric Association (APA) permits a diagnosis of gender dysphoria in adolescents and adults if the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition, (DSM-5™) are met. The criteria are:

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six month's duration, as manifested by at least **two** of the following:
  1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics); **OR**
  2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics); **OR**
  3. A strong desire for the primary and/or secondary sex characteristics of the other gender; **OR**
  4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender); **OR**
  5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender); **OR**
  6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender); **AND**
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender dysphoria is a medical condition when the elements of the condition noted above are present. Gender affirmation surgery is one treatment option. Gender affirmation surgery is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical modalities performed in conjunction with each other to help the candidate for gender affirmation achieve successful behavioral and medical outcomes. Before undertaking gender affirmation surgery, candidates need to undergo important medical and psychological evaluations, and begin medical/hormonal therapies and behavioral trials to confirm that surgery is the most appropriate treatment choice. Gender affirmation surgery presents significant medical and psychological risks, and the results are irreversible.

#### **Related Policies:**

Gonadotropin Releasing Hormone Therapy  
Androgens – NC Standard  
Estrogens

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**\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your provider.**

## Policy

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Services for gender affirmation surgery may be considered medically necessary when the criteria below are met.

Please see the following section “Benefits Application” regarding specific benefit and medical management requirements.

## Benefits Application

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Gender affirmation surgery may be specifically excluded under some health benefit plans. Please refer to the Member’s Benefit Booklet for availability of benefits.

When benefits for gender affirmation surgery are available, coverage may vary according to benefit design. Some benefit designs for gender affirmation surgery may include benefits for pelvic and/or breast reconstruction. Member benefit language specific to gender affirmation should be reviewed before applying the terms of this medical policy. This medical policy relates only to the services or supplies described herein.

When benefits for gender affirmation surgery are available coverage and availability of services may vary by State

Prior review and certification are required by most benefit plans, and when required, must be obtained or services will not be covered. Some benefit plans provide coverage without a requirement for prior approval or medical necessity review. Please refer to the Member’s Benefit Booklet for specific prior approval or medical necessity review requirements.

If prior authorization and medical necessity review are required for surgical procedures for the treatment of gender dysphoria, the medical criteria and guidelines shown below will be utilized to determine the medical necessity for the requested procedure or treatment.

## When Gender Affirmation Surgery is covered

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Gender affirmation surgery may be considered **medically necessary** when all the following candidate criteria are met and supporting provider documentation is provided:

### **SURGERY**

#### **Candidate Criteria for Adults and Adolescents age 18 years and Older for Gender Affirmation Surgery**

1. The candidate is at least 18 years of age; and
2. Has been diagnosed with gender dysphoria, including meeting all of the following indications:
  - a. A strong conviction to live as some alternative gender different from one’s assigned gender.
    - Typically accompanied by the desire to make the physical body as congruent as possible with the identified sex through surgery and hormone treatment; and
  - b. The affirmed gender identity has been present for at least 6 months; and

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- c. If significant medical or mental health concerns are present, they must be reasonably well-controlled; and
  - d. The gender dysphoria causes clinical or social distress or impairment in social, occupational, or other important areas of functioning.
3. For those candidates without a medical contraindication, the candidate has undergone a minimum of 12 months of continuous hormonal therapy that is (Note: for those candidates requesting female to male surgery see item 4. below):
  - a. Recommended by a mental health professional and
  - b. Provided under the supervision of a physician; and the supervising physician indicates that the patient has taken the hormones as directed.
4. For candidates requesting female to male surgery only:
  - a. When the initial requested surgery is solely a mastectomy, the treating physician may indicate that no hormonal treatment (as described in criteria 3. above) is required prior to performance of the mastectomy. In this case, the 12 month requirement for hormonal treatment will be waived only when all other criteria contained in this policy and in the member's health benefit plan are met.
5. The candidate has completed a minimum of 12 months of successful continuous full time real-life experience in their affirmed gender, with no returning to their gender assigned at birth. This requirement may be demonstrated by living in their affirmed gender while:
  - a. Maintaining part- or full-time employment; or
  - b. Functioning as a student in an academic setting; or
  - c. Functioning in a community-based volunteer activity as applicable. (For those candidates not meeting this criteria, see item 6. below.)
6. If the candidate does not meet the 12 month time frame criteria as noted in item 5. above, then the treating clinician must submit information indicating why it would be clinically inappropriate to require the candidate to meet these criteria. When submitted, the criteria in item 5. will be waived unless the criteria noted in item 5. above are specified as required in the candidate's health benefit plan.

## **Provider Documentation Criteria for Gender Affirmation Surgery:**

The treating clinicians must provide the following documentation. The documentation must be provided in letters from the appropriate clinicians and contain the information noted below.

1. The letters must attest to the psychological aspects of the candidate's gender dysphoria.
  - a. One of the letters must be from a licensed behavioral health professional with an appropriate degree (Ph.D., M.D., L.C.S.W., Ed.D., D.Sc., D.S.W., psychiatric physician assistant, Psy.D, or psychiatric nurse practitioner under the supervision of a psychiatrist) with established competence and clinical expertise in the assessment and treatment of gender dysphoria, who is capable of adequately evaluating if the candidate has any co-morbid psychiatric conditions. When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder) an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic.
  - b. One of the letters must be from the candidate's established physician or behavioral health provider. The letter or letters must document the following:
    1. Whether the author of the letter is part of a gender dysphoria treatment team and/or follows current WPATH Standards of Care or Endocrine Society Guidelines for the Endocrine

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- Treatment of Gender-Dysphoric/ Gender-Incongruent Persons for evaluation and treatment of gender dysphoria; and
2. The initial and evolving gender, sexual, and other psychiatric diagnoses (if applicable); and
  3. The duration of their professional relationship including the type evaluation that the candidate underwent; and
  4. The eligibility criteria that have been met by the candidate according to the above Standards of Care; and
  5. The physician or mental health professional's rationale for hormone therapy and/or surgery; and
  6. The degree to which the candidate has followed the treatment and experiential requirements to date and the likelihood of future compliance; and
  7. The extent of participation in psychotherapy throughout the 12 month real-life trial, (if such therapy is recommended by a treating medical or behavioral health practitioner) and
  8. That during the 12 month, real-life experience (for candidates not meeting the 12 month candidate criteria as noted in 6 and 7, the letter should still comment on the candidates ability to function and experience in their affirmed gender identity), persons other than the treating therapist were aware of the candidate's experience in their affirmed gender identity and could attest to the candidate's ability to function in their affirmed gender identity.
  9. Demonstrable progress on the part of the candidate in consolidating their affirmed gender identity, including improvements in the ability to handle:
    - Work, family, and interpersonal issues
    - Behavioral health issues, should they exist.
- c. If the letters specified in 1a and 1b above come from the same clinician, then a letter from a second physician or behavioral health provider familiar with the candidate corroborating the information provided by the first clinician is required.
- d. For members requesting surgical treatment, a letter of documentation must be received from the treating surgeon. If one of the previously described letters is from the treating surgeon, then it must contain the documentation noted in the section below. All letters from a treating surgeon must confirm that:
1. The candidate meets the "candidate criteria" listed in this policy and
  2. The treating surgeon feels that the candidate is likely to benefit from surgery and
  3. The surgeon has personally communicated with the treating mental health provider or physician treating the candidate, and
  4. The surgeon has personally communicated with the candidate and the candidate understands the ramifications of surgery, including:
    - The required length of hospitalizations,
    - Possible complications of the surgery, and
    - The post-surgical rehabilitation requirements of the various surgical approaches and the planned surgery.

## **Surgical procedures**

The following surgical procedures may be considered **medically necessary** if the above general criteria have been met AND the procedures are being performed only as a part of the overall treatment plan for gender dysphoria:

1. Genital procedures:
  - a. Male to Female
    - Vaginoplasty
    - Vulvoplasty
    - Repair of introitus
    - Penectomy
    - Orchiectomy

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- b. Female to Male
  - Vaginectomy
  - Vulvectomy
  - Metoidioplasty
  - Phalloplasty
  - Penile prosthesis
  - Urethroplasty/urethromeatoplasty
  - Hysterectomy
  - Salpingo-oophorectomy
  - Scrotoplasty
  - Testicular prostheses
  - Testicular expanders
- 2. Chest procedures
  - a. Male to Female
    - Breast reconstruction including augmentation with implants
  - b. Female to Male
    - Mastectomy
    - Nipple-areola reconstruction related to mastectomy reconstruction
    - Breast reduction
    - Pectoral implants
- 3. Facial procedures for facial feminization or masculinization:
  - Blepharoplasty
  - Brow lift
  - Cheek/malar implants
  - Chin contouring and implants
  - Face lift (only if done as necessary in conjunction with other facial procedures)
  - Facial bone osteoplasty
  - Forehead reduction and contouring
  - Mandible reduction, contouring, augmentation
  - Rhinoplasty

Revision surgery to correct complications or functional impairment resulting from initial gender affirming surgery may be considered **medically necessary**.

## MISCELLANEOUS SERVICES

The following are considered **medically necessary** as part of the overall treatment plan for gender dysphoria if the general criteria for treatment have been met:

- Chondrolaryngoplasty (tracheal shave)
- A limited number of electrolysis or laser hair removal sessions to prepare for approved genital surgery when the surgeon makes a recommendation documented in the medical record
- Voice therapy/voice lessons, up to 12 lessons

Gender affirmation surgery is rarely appropriate for patients under the age of 18. Requests for mastectomy for female to male transgender individuals age 17 or older may be considered only in exceptional circumstances on an individual consideration basis.

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## When Gender Affirmation Surgery are not covered

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Gender Affirmation Surgery are non-covered benefits when the member does not have benefits for the services requested contained in their health benefit plan.

Gender Affirmation Surgery is not covered when prohibited by law

Gender Affirmation Surgery is considered **not medically necessary** for plans offering gender affirmation services when the candidate criteria and provider documentation criteria are not met.

The following procedures as part of gender affirmation surgery are considered **not medically necessary**:

Abdominoplasty

Calf implants

Collagen injections

Hair transplantation

Lip filler/lip enhancement

Neck lift/tightening

Skin resurfacing (e.g. dermabrasion, chemical peels)

Laryngoplasty/voice modification surgery is considered **investigational**.

Reversal of gender affirmation surgery, except for revision surgery as outlined in the when covered section, is considered **investigational**.

Autologous tissue flap breast reconstructions are considered **not medically necessary** for gender affirmation surgery.

Fertility preservation, including but not limited to: sperm banking and embryonic freezing is considered **not medically necessary**.

## Policy Guidelines

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Gender affirmation surgery candidate criteria and care standards are based, in part, on the World Professional Association for Transgender Health (WPATH) and Endocrine Society Guidelines for Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons.

## Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*ICD-10 diagnosis codes: F64.0, F64.1, F64.2, F64.8, F64.9, Z87.890*

*Applicable codes: 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15876, 15877, 17380, 19304, 19316, 19318, 19324, 19325, 19340, 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21208, 21209, 21270, 21299, 21499, 30400, 30410, 30420, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54660, 55175, 55180, 55970, 55980, 56800, 56805, 57291, 57292, 57295, 57296, 57335, 67900.*

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*Applicable non-covered procedure codes, including, but not limited to: 11950, 11951, 11952, 11954, 15775, 15776, 15780, 15781, 15782, 15783, 15788, 15789, 15792, 15793, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879, 21208, 21210, 30430, 30435, 30450, 92507, 92508.*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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Diagnostic and Statistical Manual of Mental Disorders Fourth Edition. Text Revision (DSM-IV-TR). American Psychiatric Association. American Psychiatric Association, Inc. July 2000

Harry Benjamin International Gender Dysphoria Association, Inc (2001). Standards of Care for Gender Identity Disorders—Sixth Version. *International Journal of Transgenderism 5 (1)*. Available at: [http://www.symposion.com/ijt/soc\\_2001/index.htm](http://www.symposion.com/ijt/soc_2001/index.htm)

Day P. Trans-gender Reassignment Surgery. Tech Brief Series. New Zealand Health Technology Assessment. NZHTA Report February 2002, volume 1, Number 1. Available at: [http://nzhta.chmeds.ac.nz/publications/trans\\_gender.pdf](http://nzhta.chmeds.ac.nz/publications/trans_gender.pdf)

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The World Professional Association for Transgender Health; Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People; 7<sup>th</sup> Version; July 2012. Accessed at [http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=4655](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655) on 9/21/2016.

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American Psychiatric Association (APA). Gender dysphoria. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5™)*. Arlington, VA: American Psychiatric Publishing; 2013: 451-459.

American College of Obstetricians and Gynecologists (ACOG). Healthcare for transgender individuals. Committee Opinion. No 512. December 2011. *Obstet Gynecol* 2011; 118:1454-8.

Hembree WC, Cohen-Kettenis P, et al. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. September 2009, 94(9):3132–3154. Accessed at <http://press.endocrine.org/doi/pdf/10.1210/jc.2009-0345> on 9/21/2016.

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Specialty Matched Consultant Advisory Panel 9/2016

Senior Medical Director review 9/2016

Specialty Matched Consultant Advisory Panel 5/2017

Specialty Matched Consultant Advisory Panel 5/2018

Specialty Matched Consultant Advisory Panel 6/2019

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The World Professional Association for Transgender Health; Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People; 7<sup>th</sup> Version; July 2012. Accessed at [https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care\\_V7%20Full%20Book\\_English.pdf](https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf) on 4/27/2020

Specialty Matched Consultant Advisory Panel 5/2020

Medical Director review 7/2020

Medical Director review 9/2020

Hembree WC, Cohen-Kettenis P, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. November 2017, 102(11):3869-3903. Accessed at <https://academic.oup.com/jcem/article/102/11/3869/4157558> on 9/25/2020.

Medical Director review 3/2021

Specialty Matched Consultant Advisory Panel 4/2021

Medical Director review 6/2021

Medical Director review 9/2021

Specialty Matched Consultant Advisory Panel 4/2022

Specialty Matched Consultant Advisory Panel 4/2023

Medical Director review 9/2023

## Policy Implementation/Update Information

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- 7/19/11 New policy developed. When benefits for gender reassignment surgery are available, coverage may vary. Some benefit plans provide coverage without a requirement for prior approval or medical necessity review. Benefits for upper and/or lower body gender reassignment procedures vary by benefit plan. If prior authorization and medical necessity review are required for hormone therapy, breast augmentation surgery (mammoplasty), and mastectomy for the treatment of gender identity disorders, the medical criteria and guidelines outlined in the policy will be utilized to determine the medical necessity for the requested procedure or treatment. (adn)
- 9/18/12 Added diagnosis codes 302.0, 302.5, 302.50 – 302.53, 302.6, 302.85, 302.9, 313.82, 752.7 to Billing/Coding section. (sk)
- 1/1/13 Reference added. Specialty Matched Consultant Advisory Panel review 12/4/12. No change to policy statement. (sk)
- 7/1/13 ICD-10 diagnosis codes added to Billing/Coding section. (sk)
- 10/29/13 Reference added. Replaced DSM-IV TR criteria with DSM-5™ criteria. Removed “Sex change surgical procedures other than breast augmentation surgery (mammoplasty) and mastectomy” from the When Not Covered section. Added “pelvic reconstruction” to the When Covered section. Applicable Service Codes removed from Billing/Coding section. Senior Medical Director review. (sk)



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- 7/1/14 Removed ICD-10 effective date from Billing/Coding section. (sk)
- 12/9/14 Reference added. Specialty Matched Consultant Advisory Panel review 11/24/14. No change to policy statement. (sk)
- 12/30/15 Specialty Matched Consultant Advisory Panel review 11/18/2015. (sk)
- 9/30/16 Specialty Matched Consultant Advisory Panel review 9/2016. Policy re-titled to Gender Confirmation Surgery and Hormone Therapy. Information regarding coverage of services for adolescents added to the “When Covered” section. Fertility preservation, including but not limited to: sperm banking and embryonic freezing added to Non-covered section. ICD 9 codes removed from Billing/Coding section. ICD 10 codes, covered codes and non-covered codes added to Billing/Coding section. Policy noticed 10/1/2016 for policy effective date 1/1/2017. (sk)
- 6/30/17 Specialty Matched Consultant Advisory Panel review 5/31/2017. (sk)
- 6/29/18 Specialty Matched Consultant Advisory Panel review 5/23/2018. (sk)
- 7/16/19 Specialty Matched Consultant Advisory Panel review 6/28/2019. (sk)
- 6/23/20 Reference added. Specialty Matched Consultant Advisory Panel review 5/20/2020. (sk)
- 8/25/20 Medical Director review. Provider Documentation Criteria updated to include “licensed” behavioral health professional, and “with established competence and clinical expertise in the assessment and treatment of gender dysphoria”. (sk)
- 11/10/20 Medical Director review. Policy title changed from “Gender Confirmation Surgery and Hormone Therapy” to “Gender Affirmation Surgery and Hormone Therapy”. The word “confirmation” changed to “affirmation” throughout the policy. In the When Covered section, Candidate Criteria for Adults and Adolescents age 18 years and older, criteria 2, wording changed from “the desire to live and be accepted as a member of the opposite sex” to “A strong conviction to live as some alternative gender different from one’s assigned gender”. In the When Covered section, Candidate Criteria for Children and Adolescents under age 18 years, criteria 1a, wording changed from “the desire to live and be accepted as a member of the opposite sex” to “A strong conviction to live as some alternative gender different from one’s assigned gender”. When Covered section updated to include information on medically necessary hair removal prior to genital surgery. References updated. (sk)
- 3/23/21 Medical Director review. Removed “That the candidate has, intends to, or is in the process of acquiring a legal gender-identity appropriate name change and” from the list of Provider Documentation Criteria for Gender Affirmation Surgery. (sk)
- 7/1/21 Medical necessity criteria added for facial surgery. Added specificity for which genital and chest procedures are covered. Tracheal shave and voice lessons added as medically necessary. Laryngoplasty added as investigational. Reversal surgery added as investigational. Several not medically necessary surgical and cosmetic services added as not medically necessary. Billing/Coding section updated. (hb/sk)
- 10/1/21 Medical Director review. Wording changes made throughout policy as follows: 1. Where policy wording stated, “new gender identity” changed to “affirmed gender identity”. 2. Where policy wording stated, “original gender” changed to “gender assigned at birth”. 3. Where

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policy wording stated, “desired gender role” changed to “their affirmed gender identity”. 4.  
Where policy wording stated, “the new role” changed to “their affirmed gender identity”. (sk)

6/14/22 Specialty Matched Consultant Advisory Panel review 4/20/2022. (sk)

11/15/22 Codes 15876 and 15877 moved from noncovered to covered in Billing/Coding section per management review. (sk)

6/30/23 Specialty Matched Consultant Advisory Panel review 4/19/2023. (sk)

10/10/23 Policy title changed from “Gender Affirmation Surgery and Hormone Therapy” to “Gender Affirmation Surgery”. Under “When Covered” section removed Hormonal Therapy. Hormone therapy is addressed by Corporate Pharmacy Clinical Management. Added related policies Gonadotropin Releasing Hormone Therapy, Estrogens, and Androgens – NC Standard. Removed codes C1813, C2622, J1950, J3315, J9217, J9219, J9226 from billing section. Under “Benefits Application” section added statement When benefits for gender affirmation surgery are available coverage and availability of services may vary by State. Under “Not Covered” section added statement Gender Affirmation Surgery is not covered when prohibited by law. Medical Director review 09/2023.(rp)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.