

Medical Policy

Policy: 201609

Effective Date: 06/01/2025

SUBJECT: Gender Affirming Surgery

Annual Review Date: 03/28/2025

Last Revised Date: 03/28/2025

Prior approval is required for some or all procedure codes listed in this Corporate Medical Policy.

Definition: Gender dysphoria* is the discomfort or distress that is caused by a discrepancy between an individual's gender identity and that individual's sex assigned at birth. Medical treatment of gender dysphoria includes hormone therapy and/or surgery, as well as psychotherapy including counseling and support. Gender affirming surgery refers to surgical procedures for the treatment of gender dysphoria. These types of surgeries may include several staged procedures.

Medical Mutual of Ohio respects gender diversity and has developed this corporate medical policy to assist our members who are diagnosed with gender dysphoria. This policy applies only to members diagnosed with gender dysphoria. Gender fluidity and other expressions of gender identity without a diagnosis of gender dysphoria are not covered by this policy.

Medical Necessity: The Company considers gender affirming surgery **medically necessary** and eligible for reimbursement providing that the following criteria are met:

For gender affirming chest surgery:

- A written assessment* from at least one qualified behavioral health professional** with competencies in the assessment of transgender and gender diverse people that documents that the individual meets **all** of the following:
 - ≥ 18 years old; and
 - Capacity to make a fully informed decision and consent for treatment that may be irreversible; and
 - Persistent, well-documented diagnosis of gender dysphoria***; and
 - Absence of poorly controlled or unstable psychiatric condition; and
 - Gender incongruence is marked and sustained.

NOTE: Individuals under 18 years of age may be eligible for gender-affirming chest surgery providing that the above criteria are met (except for age) and the individual has completed at least 12 months of hormone therapy, unless medically contraindicated or hormone therapy is not desired.

For gender affirming genital surgery:

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- A written assessment* from at least one qualified behavioral health professional** with competencies in the assessment of transgender and gender diverse people that documents that the individual meets **all** of the following:
 - ≥ 18 years old; and
 - Capacity to make a fully informed decision and consent for treatment that may impact reproduction and may be irreversible; and
 - Persistent, well-documented diagnosis of gender dysphoria***; and
 - Absence of poorly controlled or unstable psychiatric condition; and
 - Stable hormone therapy treatment regimen of at least 6 continuous months unless medically contraindicated or hormone treatment is not desired; and
 - Gender incongruence is marked and sustained.

Medically necessary surgical procedures may include the following:

- Breast augmentation, clitoroplasty, coloproctostomy, labiaplasty, orchiectomy, penectomy, vaginoplasty, urethroplasty, vulvoplasty, bilateral mastectomy or breast reduction, hysterectomy, implantation of penile and/or testicular prostheses, metoidioplasty, nipple-areola reconstruction following gender-affirming mastectomy†, salpingo-oophorectomy, urethroplasty, phalloplasty, scrotoplasty, vaginectomy, vulvectomy.

The Company considers certain procedures that may be related to gender affirming surgery to be **cosmetic** and **not** eligible for reimbursement, including but not limited to the following:

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| • Abdominoplasty | • Laryngoplasty |
| • Blepharoplasty | • Lipofilling |
| • Botulinum toxin | • Liposuction or lipoplasty |
| • Brow lift | • Lip reduction/enhancement |
| • Calf implants | • Neck tightening |
| • Collagen injections | • Pectoral implants |
| • Dermal filler injections | • Removal of redundant skin |
| • Facial implants | • Rhinoplasty |
| • Facial modifications including facial feminization and face lift | • Skin resurfacing |
| • Gluteal augmentation including implants/lipofilling | • Thyroid chondroplasty (reduction of the Adam's apple) |
| • Hair reconstruction including permanent hair removal†† or hair transplant | • Other aesthetic or cosmetic procedures not listed |

Please note that while the above procedures may not be covered under this Corporate Medical Policy, members may be eligible when certain criteria are met. Please consult our library of Corporate Medical Policies for further details.

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†**NOTE:** CPT code 19318 (breast reduction) includes the work necessary to reposition and reshape the nipple and areola. CPT code 19350 (nipple/areola reconstruction) is considered integral to CPT code 19318; thus CPT codes 19350 and 19318 should not be billed together for mastectomy for the purpose of gender affirming surgery. However, when appropriate, CPT code 19350 may be requested along with CPT code 19303 (mastectomy, simple, complete).

††**NOTE:** Laser or electrolysis hair removal (**CPT Code 17380**) to treat tissue donor sites for a planned genital surgery, when prescribed by a physician for treatment for gender dysphoria, is considered **medically necessary** and eligible for reimbursement.

The Company considers certain procedures as **not medically necessary** and **not** eligible for reimbursement when performed as part of gender affirming surgery, including but not limited to the following:

- Speech therapy for vocal training.
- Vocal cord procedures (voice modification surgery).
- Gender affirming surgeries for diagnoses other than gender dysphoria.

OTHER IMPORTANT NOTES:

- Reversal of gender affirming surgery is considered **medically necessary** and eligible for reimbursement providing that the medical necessity criteria above are met.
- Coverage for fertility preservation services (cryopreservation, storage and thawing of reproductive tissue) is subject to limitations or exclusions in the individual's health benefit plan. Please consult plan documents for more information.
- Certain gender-specific services may be considered **medically necessary** for transgender persons appropriate to their anatomy. Examples include:
 - Breast cancer screening for transmasculine persons who have not undergone chest masculinization surgery;
 - Prostate cancer screening for transfeminine persons who have retained their prostate.
- Hormone therapy is subject to the individual's prescription drug benefit plan.
- Certain plan certificate books may exclude coverage for surgical and non-surgical management of gender dysphoria. To verify coverage, refer to member mailings and updated certificate books as they become available.

***Written documentation includes a letter of referral and should cover six key elements:**

1. The patient's general identifying characteristics.
2. Results of the patient's psychosocial assessment including any diagnoses.
3. Duration of the mental health professional's relationship with the patient including the type and duration of counseling or therapy to date.
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale supporting the patient's request for surgery.
5. A statement confirming that informed consent has been obtained from the patient.

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6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this relationship.

****World Professional Association for Transgender Health Standards of Care version 8 (2022)** recommends the following characteristics of a qualified health professional:

1. Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
2. Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
3. Are able to assess capacity to consent for treatment.
4. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
5. Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.
6. Liaise with professionals from different disciplines within the field of transgender health for consultation and referral on behalf of gender diverse adults seeking gender-affirming treatment, if required.

World Professional Association for Transgender Health Standards of Care version 8 (2022) recommends that a qualified surgeon has the following credentials:

1. Training and documented supervision in gender-affirming procedures;
2. Maintenance of an active practice in gender-affirming surgical procedures;
3. Knowledge about gender diverse identities and expressions;
4. Continuing education in the field of gender-affirmation surgery;
5. Tracking of surgical outcomes.

*****Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision Criteria for Gender Dysphoria (APA, 2022):**

Gender dysphoria in Adolescents and Adults

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months 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).
 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 (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

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6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 2.55.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Post transition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender affirming surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female).

Medical Mutual of Ohio complies with the Mental Health Parity and Addiction Equality Act (MHPAE). This Corporate Medical Policy applies to covered plans (individual and group) which are subject to the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) and to groups who may be exempt from the requirements of MHPAEA but still elect to provide coverage.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.

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Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.

Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.

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Sources of Information:

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 - Gender-Affirming Body-Contouring Procedures in Patients with Gender Dysphoria. (2023, September 13). Annual review September 20, 2024.
 - Gender-Affirming Hair Removal for Patients With Gender Dysphoria. (2023, June 15). Annual review June 14, 2024.
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 - Masculinizing Voice and Communication Therapy for Gender Dysphoria. (2022, September 8). Annual review September 20, 2024.
 - Sex Reassignment Surgery for the Treatment of Gender Dysphoria. (2018, August 1). Annual review July 27, 2022.
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- Loree JT, Burke MS, Rippe B, Clarke S, Moore SH, Loree TR. (2020). Transfeminine Gender Confirmation Surgery with Penile Inversion Vaginoplasty: An Initial Experience. *Plast Reconstr Surg Glob Open*, 8(5):e2873.
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 - Ferrando C. (2024). Gender-affirming surgery: Male to female. Brubaker L (Ed).

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Applicable Code(s):	
CPT:	17380, 17999, 19303, 19318, 19325, 19340, 19342, 19350, 44145, 53430, 54125, 54400, 54401, 54405, 54520, 54660, 54690, 55180, 55970, 55980, 56625, 56800, 56805, 56810, 57106, 57110, 57291, 57292, 57295, 57335, 58150, 58262, 58291, 58552, 58554, 58570, 58571, 58572, 58573, 58661
HCPCS:	L8699
ICD-10-CM Procedure Codes	0UQG0ZZ, 0UQJ0ZZ-0UQJXZZ, 0UT20ZZ-0UT2FZZ, 0UT70ZZ-0UT7FZ, 0UT90ZZ-0UT9FZZ, 0UTC0ZZ-0UTC8ZZ, 0UTG0ZZ-0UTG8ZZ, 0UTJ0ZZ-0UTJXZZ, 0UTM0ZZ-0UTMXZZ, 0VRC0JZ, 0VTC0ZZ-0VTC4ZZ, 0VTS0ZZ-0VTSXZZ, 0VUS07Z-0VUSX7Z, 0VUS0JZ-0VUSXJZ, 0VUS0KZ-0VUSXKZ, 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0, 0W4N071, 0W4N0J1, 0W4N0K1, 0W4N0Z1
ICD10 Diagnosis Codes:	F64.0, F64.1, F64.2, F64.8, F64.9