Clinical Policy Title: Gender dysphoria

Clinical Policy Number: CCP.1358

Effective Date:	**March 1, 2018**
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Policy contains:

- Gender dysphoria.
- Gender reassignment surgery.
- Transgender reassignment.
- Transmen.
- Transwomen.

Related policies:

None.

ABOUT THIS POLICY: *AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.*

Coverage policy

AmeriHealth Caritas considers the use of medical and surgical treatment for gender dysphoria to be clinically proven and, therefore, medically necessary when the following criteria are met:

I. Candidate Criteria:

A. The member is an adult age 18 or older, or documented as an emancipated adolescent, or has documentation of appropriate consent from parent or guardian.

B. The member has the capacity to make fully informed decisions and consent for treatment.

C. The member has received a diagnosis of gender dysphoria by a qualified health professional. The diagnosis must be based on:

1. Strong and persistent cross-gender identification. In adolescents and adults, the condition is manifested by symptoms such as a stated desire to be the other gender, frequent passing as the other gender, desire to live or be treated as the other gender, or the conviction that he or she has the typical feelings and reactors of the other gender.
2. Persistent discomfort (dysphoria) with his/her gender or sense of inappropriateness in the gender role of that sex.

3. The dysphoria is not concurrent with a physical intersex condition.
4. The dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The member desires to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his/her body conform as much as possible to the preferred sex through surgery and hormone treatment.
E. The member has had real-life experience of at least 12 months in his/her desired gender.
F. Gender dysphoria is not a symptom of another mental disorder.

II. Qualifications of Providers:

Providers of diagnostic and therapeutic services for child, adolescent, and adult gender dysphoria will have the following qualifications:

A. A master's degree or higher in a clinical behavioral science field, from an accredited institution.
B. Training in psychopathology for adults or children/adolescence.
C. Competence in using the International Classification of Diseases and/or Diagnostic Statistical Manual of Mental Diseases.
D. Competence in recognizing and diagnosing mental conditions co-existing with gender dysphoria.
E. Training and competence in psychotherapy or counseling.
F. Knowledge of gender non-conforming diseases, and assessment/treatment of gender dysphoria.
G. Continuous education in the diagnosis and treatment of gender dysphoria.
H. Training and competence in treating ordinary disorders of adults or children/adolescents.

III. Referrals for Surgical Procedures

One or more referrals from a qualified mental health professional are necessary for certain procedures, including:

A. Breast/chest surgery, including mastectomy, chest reconstruction, and augmentation mammoplasty (one letter).
B. Genital surgery, including hysterectomy, salpingo-oophorectomy, orchiectomy, and genital reconstruction (two letters, one from the member's psychotherapist, one from a professional who had an evaluative role).

Referral letters should include member identification, results of psychosocial assessments, duration of practitioner relationship with the member, a statement explaining that the criteria for surgery have been met, a statement that the member has given informed consent, and a statement that the practitioner is available for coordination of care.

IV. Surgical Procedures –

A. Breast/Chest Surgery. Breast augmentation and mastectomy for female to male (transmen) and creation of male chest for male to female (transwomen) members are considered medically necessary when the following criteria are met:
    1. Persistent gender dysphoria is well documented.
    2. Member has the capacity to make informed decisions and consent to treatment.

3. Member is of majority (adults only).
4. Any significant medical or mental health concerns are controlled.
5. Member has had at least 12 months of feminizing hormone therapy (recommended for breast augmentation).
6. One letter of referral is submitted.

B. Genital Surgery. Hysterectomy and ovariectomy (transmen), orchiectomy (transwomen), metoidioplasty (transmen), and phalloplasty (transwomen) are considered medically necessary when the following criteria are met:
   1. Persistent gender dysphoria is well documented.
   2. Member has the capacity to make informed decisions and consent to treatment.
   3. Member is of majority in a given country.
   4. Any significant medical or mental health conditions are controlled.
   5. Member must have had 12 consecutive months of hormone therapy as appropriate to the member's gender goals (unless the member has a medical contradiction or is unable/unwilling to take the hormones).
   6. Member must have 12 continuous months of living in a gender role congruent with their gender identify (metoidioplasty and phalloplasty only).
   7. Two letters of referral are submitted.

C. Other Surgeries. The following surgeries are considered medically necessary, if criteria B1 – B5 above are fulfilled, and one letter of referral is submitted:
   1. Clitoroplasty.
   2. Labiaplasty.
   3. Mammaplasty.
   4. Penectomy.
   5. Salpingo-oophorectomy.
   6. Scrotoplasty.
   7. Testicular prosthesis.
   8. Veginectomy.
   9. Vaginoplasty.
   10. Vulvectomy.
   11. Urethroplasty.

V. Hormone therapy.

A. Adults. Various hormones are given to adult members undergoing gender transformation. The specific hormones vary by individual, but in all cases, the following criteria must be observed:
   1. Persistent gender dysphoria is well documented.
   2. Member has the capacity to make informed decisions and consent to treatment.
   3. Member is of majority in a given country.
   4. Any significant medical or mental health conditions are controlled.
   5. Hormones are not to be administered unless the member has a medical contraindication or

is unable/unwilling to take hormones.

B. Adolescents. Various hormones can be given to members not of majority age undergoing gender transformation. Similar to adults, the specific hormones vary by individual, but often serve to suppress puberty in the member's birth gender. All cases must observe the following criteria:
   1. The member has a long-lasting and intense pattern of gender nonconformity or dysphoria.
   2. Gender dysphoria emerged or worsened with the onset of puberty.
   3. Any co-existing psychological, social, or medical problems that could interfere with treatment have been addressed, and the member's condition is stable.
   4. The member has given informed consent, or (if not of age) parents, other caretakers, or guardians have consented to treatment and are involved in the treatment process.

VI. Psychotherapy. Psychotherapy to child, adolescent, and adult members is considered medically necessary (but not mandatory) before, during, and after gender reassignment, by a credentialed and experienced professional trained in psychotherapy, even if the service is unrelated to gender concerns. (World Professional Association for Transgender Health, 2011).

For any determinations of medical necessity for medications, refer to the applicable state-approved pharmacy policy.

Limitations:

All other uses of services related to gender dysphoria are not clinically proven, and therefore not medically necessary. A number of procedures related to gender dysphoria treatment can be considered cosmetic, and therefore, not medically necessary, unless a functional impairment justifying the procedure as medically necessary is documented. These procedures include, but are not limited to:

- Blepharoplasty.
- Brow lift.
- Chin augmentation.
- Facial bone reconstruction.
- Facial bone reduction.
- Face lift.
- Hair removal/hairplasty.
- Laryngoplasty.
- Lip reduction/enhancement.
- Liposuction.
- Reduction thyroid chondroplasty.
- Rhinoplasty.

Alternative covered services:

None.

Background

Gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics (Knudson, 2010). This differs from gender nonconformity, defined as a person's gender identify, role, and expression differs from cultural norms of a particular sex (Institute of Medicine, 2011). Only some persons with gender nonconformity experience gender dysphoria. Gender dysphoria was first identified by endocrinologist Harry Benjamin as a condition distinct from transsexualism in the mid-20th century.

The Diagnostic and Statistical Manual of Mental Disorders, produced by the American Psychiatric Association, separates gender dysphoria definitions by children and adolescents/adults (American Psychiatric Association, 2013). Adults and adolescents are considered to have gender dysphoria if a difference between one's assigned and experienced/expressed gender exists, lasting at least six months, and includes at least two of the following six indicators:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
- A strong desire to be rid of one's primary and/or 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.
- A strong desire to be treated as the other gender.
- A strong conviction that one has the typical feelings and reactions of the other gender.

The American Psychiatric Association's definition of gender dysphoria in children is a marked incongruence between the assigned and experienced/expressed gender, lasting at least six months, and includes at least five of the following indicators:

- A strong desire to be of the other gender or an insistence that one is the other gender.
- A strong preference for wearing clothes typical of the opposite gender.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- A strong rejection of toys, games, and activities typical of one's assigned gender.
- A strong dislike of one's sexual anatomy.
- A strong desire for the physical sex characteristics that match one's experienced gender (American Psychiatric Association, 2013).

The prevalence of gender dysphoria in populations may vary by level of cultural and social acceptance in each nation. Moreover, most estimates that have been made are from European nations. Prevalence of

self-reported transgender identify in children, adolescents, and adults ranges from 0.5 percent to 1.3 percent, which is considerably greater than estimates based on clinic-referred adult samples (Zucker, 2017). During the past 50 years, reported prevalence has increased; current estimated prevalence, based on 12 studies, is 6.8 and 2.6 per 100,000 for transwomen and transmen (Arcelus, 2015).

Whether the member is a child, adolescent, or adult, properly trained and experienced mental health professionals working with gender dysphoria members play the key role in assessing each case, and recommending the type of treatment needed. Important aspects of assessment include working with families, understanding any other mental and other disorders, educate and advocate on behalf of gender dysphoric persons, and provide members with referrals for peer support (World Professional Association for Transgender Health, Inc., 2011).

Four categories of treatments for gender dysphoria exist:

- Changes in gender expression/role (which may involve living part/full-time in another gender role).
- Hormone therapy to feminize or masculinize the body.
- Surgery to change sex characteristics (e.g., breast, genitalia, facial features, body contouring).
- Psychotherapy to explore gender identity, role, and expression; addressing negative impact of gender dysphoria; alleviating internalized transphobia; enhancing social/peer support; improving body image; or promoting resilience (World Professional Association for Transgender Health, Inc., 2011).

Not all persons with gender dysphoria will undergo surgery. Of those who do, surgical procedures typically include (for transwomen) facial feminization surgery, voice surgery, breast augmentation, orchiectomy, and vaginoplasty; and (for transmen) facial masculinization surgery, subcutaneous mastectomy, and phalloplasty procedures (Colebunders, 2017).

Other options for social support and changes in gender expression include peer support organizations and resources for members, friends and families; voice and communication therapy to help individuals acquire comfort with their new identity; hair removal; breast binding/padding, penile prostheses, and hip/buttock padding; and changes in name and gender marker (World Professional Association for Transgender Health, Inc., 2011).

Behavior that may represent gender dysphoria can occur as early as age two, but such behavior often does not continue beyond the onset of puberty, and only 12 to 27 percent persist into adulthood (Drummond, 2008). Many cases originate in adolescence or adulthood. Mental health professionals who treat children and adolescents with gender dysphoria should assess, rather than dismiss, attitudes toward nonconforming gender identities. Education about potential treatment approaches should be shared with members and their families (World Professional Association for Transgender Health, Inc., 2011).

As in any medical service, risks exist in the treatment of gender dysphoria. The surgeries involved each have a risk in the technical execution of the procedure. In addition, hormone therapy (both masculinizing and feminizing) can raise risk of certain symptoms or disorders. Risk from psychotherapy services typically are a result of incorrect diagnosis from lack of understanding gender dysphoria (World Professional Association for Transgender Health, Inc., 2011).

One issue raised in gender transformation is that of a patient's desire to reproduce in the future. Health providers should discuss reproductive options with patients whenever possible, preferably before any surgical or hormonal treatment begins, so that any decisions made by the patient will be educated ones. Frozen embryos and sperm preservation are two of the options a patient may consider (World Professional Association for Transgender Health, Inc., 2011).

Any transsexual or transgender person will require care for the rest of their lives. Much of this care is best done as preventive care, to ensure no unnecessary adverse outcomes of the transgender treatment causes harm to the patient. Screenings for cardiovascular risk factors, osteoporosis, and some cancers are examples of these preventive services. Urogenital care is also important. Regardless of the potential health issue, counseling to the patient is important (World Professional Association for Transgender Health, Inc., 2011).

Issues of harassment, discrimination, and rejection of transgender individuals are a threat in the United States and many societies. A committee of the American College of Obstetricians and Gynecologists produced an opinion opposing such discrimination. The opinion noted that of transgender youth, 54 percent have attempted suicide, 21 percent resort to self-mutilation, and over 50 percent have injected illegal hormones. The committee thus recommended insurance plans to cover treatment of these individuals (American College of Obstetricians and Gynecologists, 2011).

Searches

AmeriHealth Caritas searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality Guideline Clearinghouse.
- The Centers for Medicare & Medicaid Services.
- Cochrane Reviews.

Searches were conducted on November 27, 2018. Search terms were "gender confirmation surgery," "gender dysphoria," "gender identity disorder," and "transsexualism,"

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a

scientific endeavor, and are thus rated highest in evidence-grading hierarchies.

- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

Findings:

The World Professional Association for Transgender Health has issued Standards of Care, beginning in 1979 and most recently, the 7th version, in 2011. The next version is due in late 2018 or early 2019. The Association describes these Standards as flexible clinical guidelines that include criteria for hormone therapy and surgical treatments, along with psychotherapy, and that can be adapted by practitioners to individual patients, and for social and cultural differences (World Professional Association for Transgender Health, 2011).

A key aspect of the Association's standards, along with other guidelines, is that patients are to engage in at least 12 continuous months of living in a gender role congruent with their gender identity, before surgery is considered medically necessary. A period of 12 months will ensure that the person will experience all events that occur annually, such as family events, holidays, vacations, season-specific work, or school experiences, in the desired gender role. Care givers should discuss patient experience with these events, and document the patient's progress during the 12 month period (Bockting, 2008; World Professional Association for Transgender Health, Inc., 2011).

Other professional associations that have issued clinical guidelines on gender dysphoria include the American Academy of Child and Adolescent Psychiatry (Adelson, 2012), American College of Obstetricians and Gynecologists (2011, 2017), American Psychiatric Association (Byne, 2012), American Psychological Association (2015), Australian and New Zealand Professional Association for Transgender Health (Telfer, 2018), Endocrine Society (Hembree, 2017), Royal College of Psychiatrists (2013), and University of California at San Francisco (Deutsch, 2016). In a review of treatment of gender identify disorder by a task force of the American Psychiatric Association, quality of evidence was found to be generally low, but sufficient to support the Association's treatment recommendations (Byne, 2012).

On August 30, 2016, the Centers for Medicare and Medicaid Services issued a decision memo. Instead of producing a National Coverage Determination on gender reassignment surgery, the Centers announced coverage decisions would be made by local Medicare administrative contractors on a case-by-case basis. The decision was based on the Centers opinion that "clinical evidence is inconclusive for the Medicare population." It advised the Medicare administrative contractors to make decisions on surgery based on "reasonable and necessary" criteria, and also encouraged that more studies be conducted to improve decisions and eventual health outcomes (Centers for Medicare & Medicaid Services, 2016).

Gender reassignment involves multiple surgical procedures. One early systematic review assessed 82 studies that included 13 procedures. Assessment of five procedures for transwomen, three (labiaplasty,

orchiectomy, penectomy) failed to produce evidence satisfying inclusion criteria, with a large amount of evidence supporting vaginoplasty and clitoroplasty. Satisfactory outcomes were consistently reported for the eight transmen procedures. Authors cite a lack of controlled studies, a lack of prospective data collection, high loss to follow up, and insufficient validation measures (Sutcliffe, 2009).

A study evaluating surgical complications in gender reassignment involved 332 persons undergoing transwomen reassignment showed progressive obstructive voiding disorder due to meatal stenosis in 40 percent of patients, which were corrected during follow up. Stricture recurrence and stricture of vaginal introitus were each found in 15 percent of the cases, vaginal stenosis (12 percent), and loss of vaginal depth (eight percent) (Rossi-Neto, 2012). A recent review of neovaginal complications in the transwomen reassignment surgical patients included 13 studies (n = 1684). The complication rate was 32.5 percent, with a re-operation rate for non-aesthetic reasons of 21.7 percent (Dreher, 2018).

Few articles on risks of particular procedures used in gender reassignment surgery are available. One review of 21 studies (n = 894) assessed risks of vaginoplasty. The most common complication was introital stenosis, requiring surgical correction in 4.1 percent and 1.2 percent of sigmoid- and ileum-derived vaginoplasties. Sexual satisfaction was high, but quality of life not reported (Bouman, 2014).

A systematic review of 110 instruments found a substantial lack of patient-reported health outcomes valid for the transgender population after gender reassignment surgery (Andreasson, 2018).

A systematic review of 13 studies assessed the psychosocial, cognitive and/or physical effects of hormonal therapy on the transgender population. Studies included reviews of gonadotropin-releasing hormone agonist (*n* = 9), estrogen (*n* = 3), testosterone (*n* = 5), antiandrogen (cyproterone acetate) (*n* = 1), and progestin (lynestrenol) (*n* = 1). Most treatments achieved intended physical effects; gonadotropin-releasing hormone agonist treatment improved multiple psychological measures (but not gender dysphoria); and psychosocial effects of hormones are not adequately assessed (Chew, 2018).

Some peer-reviewed articles address health outcomes of persons with gender dysphoria. One of these included 1,331 Dutch persons with gender dysphoria given cross-sex hormone therapy, initiated prior to 1997, of whom 88.4 percent (n = 1181) underwent reassignment surgery. A total of 134 of the 1,331 patients died (all-causes), a rate 51 percent greater than that of the general population of the same age. The male-to-female death rate was significantly greater than the female-to-male rate (12.6 to 3.3 percent, n = 122 and n = 12). Significantly greater rates of death in the transwomen population included ischemic heart disease in older persons (n = 18 deaths), suicide (n = 17), acquired immune deficiency syndrome (n = 16), illicit drug use (n = 5), and unknown causes (n = 21) (Asscheman, 2011).

Another long-term study compared 324 Swedish persons with gender dysphoria who underwent reassignment surgery and 3,240 controls. Median follow up for all-cause mortality and psychiatric hospitalization were 11.4 and 10.4 years, respectively. In the period 1973-2003, the incidence rate per person years was significantly higher for cases, for all deaths (7.3 percent — 27 of 99 — versus 2.5 percent — 99 of 3,240), psychiatric hospitalizations, substance misuse, suicide attempts, any crime, and

violent crime. Non-significantly elevated rates were observed for cardiovascular deaths, neoplasm deaths, and accidents (Dhejne, 2011).

One study tracked mortality patterns during the years 2000 to 2009 for 5,117 hospital patients who were U.S. veterans, who had at least one diagnosis consistent with transgender status. Of those, 309 (9.3 percent) were identified in the National Death Index as having died during the 10-year period. Circulatory diseases and neoplasms were the most commonly reported causes of death, similar to the general population. However, the suicide rate in the transgender veteran population was calculated to be 82 deaths per 100,000 person-years — similar to rates for veterans with other serious mental conditions such as depression and schizophrenia, and higher than the rate in the non-veteran transgender population (Blosnich, 2014).

Measures of mental health have been compared before and after treatment. A review of two cohort studies (n=154) analyzed results of a self-reported questionnaire before and after administration of hormone therapy, at six and 12 months. Significant improvements were observed for psychoneurotic stress, depression, anxiety, somatization, interpersonal sensitivity, hostility, and phobic anxiety (White Hughto, 2016). Similar improvements were found in a systematic review of 17 studies of body uneasiness emotional functioning; male-to-female subjects benefited the most (Costa, 2016).
A review of 28 studies (n = 1833) provided results for mental health, quality of life, and sexual function within the transgender population, including male to female and female to male. Despite most studies lacking control groups, pooled results document that after sex reassignment, significant improvements were reported by subjects in gender dysphoria (80 percent), psychological symptoms (78 percent), quality of life (80 percent), and sexual function (72 percent) (Murad, 2010).

Studies have explored satisfaction and quality of life issues in the transgender population. One review of 19 studies (n = 2299) included 17 patient-reported outcome measures and 10 generic quality of life instruments, plus several others. While some patterns have emerged, authors agree a new self-assessment tool is needed, including functional, psycho-relational, and cosmetic components, for more consistent analyses (Barone, 2017).

One significant aspect of quality of life after gender reassignment surgery and hormone therapy is the level of sexual function. A review found that in transwomen subjects, rates of hypoactive sexual desire disorder are similar to those in the general female population. While more research is needed, it appears that sexual arousal and orgasmic functioning increase after surgery and hormone therapy (Klein, 2009).

Despite such methodological limits, reviews have provided information on quality of life. One study of 247 transwomen found a statistically lower ($P < .05$) quality of life in those with no surgical intervention compared to those with gender reassignment surgery and the overall female population. Subjects with female feminization surgery have a significantly higher ($P < .01$) quality of life scored than those who did not (Ainsworth, 2010).

Some surgeries used in gender reassignment use multiple techniques. In one review of 26 studies, vaginoplasty in transwomen used penile skin inversion (n= 1461) and bowel vaginoplasty (n = 102). Sexual function and patient satisfaction was acceptable, even though authors had difficulty comparing the two processes (Horbach, 2015).

Other studies explore the extent of regrets about transgender surgery. In a review of 681 Swedes who had undergone surgery and changed legal status, 2.2 percent later applied to reverse the new status. This number may be an undercount, as some requests may have occurred after publication submission and because other expressions of regret such as suicide are not included (Dhejne, 2014).

Several articles have asserted that rates of autism spectrum disorder are higher in transgender persons, although there is no agreement yet on the cause of this pattern (van Schallwyk, 2015).

Policy updates:

In November 2018, we identified several new systematic reviews and meta-analyses for inclusion in the policy.

A total of two peer-reviewed references were added to, and two peer-reviewed references removed from this policy in November, 2018.

The policy number was changed from 17.03.03 to CCP.1358 in November 2018.

References

Professional society guidelines/other:

Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues: Practice Parameter on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents. *J Am Acad Child Adolesc Psychiatry*. 2012;51(9):957-974. Doi: 10.1016/j.jaac.2012.07.004.

American College of Obstetricians and Gynecologists, Committee on Adolescent Health Care (ACOG). Committee Opinion #685. Care for transgender adolescents. . https://www.acog.org/-/media/Committee-Opinions/Committee-on-Adolescent-Health-Care/co685.pdf?dmc=1&ts=20170213T1932201975. Published January, 2017. Accessed November 27, 2018.

American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women. Committee Opinion #512. Health care for transgender individuals. *Obstet Gynecol*. 2011;118(6):1454-1458. Doi: 10.1097/AOG.0b013e31823ed1c1.

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

American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. *Am Psychol*. 2015;70(9):832-864. Doi: 10.1037/a0039906.

Byne W, Bradley SJ, Coleman E, et al. Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. *Arch Sex Behav*. 2012;41(4):759-796. Doi: 10.1007/s10508-012-9975-x.

Committee on Health Care for Underserved Women (ACOG). Committee Opinion no. 512: health care for transgender individuals. *Obstet Gynecol*. 2011;118(6):1454-1458. Doi: 10.1097/AOG.0b013e31823ed1c1.

Deutsch MB (ed). Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People. University of California-San Francisco, Center on Excellence for Transgender Health. 2nd Edition. http://transhealth.ucsf.edu/protocols. Published June 17, 2016. Accessed November 27, 2018.

Hembree WC, Cohen-Kettenis P, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017.; 102(11):3869-3903. Doi: 10.1210/jc.2017-01658.

Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.. https://www.ncbi.nlm.nih.gov/books/NBK64795/. Published 2011. Accessed November 27, 2018.

Royal College of Psychiatrists (RCP). Good practice guidelines for the assessment and treatment of adults with gender dysphoria. http://www.rcpsych.ac.uk/files/pdfversion/CR181_Nov15.pdf. Published 2013. Accessed November 9, 2017.

Telfer MM, Tollit MA, Pace CC, Pang KC. Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. *Med J Aust*. 2018;209(3):132-136. https://www.ncbi.nlm.nih.gov/pubmed/?term=Telfer+MM%2C+Tollit+MA%2C+Pace+CC%2C+Pang+KC. Accessed November 7, 2018.

U.S. Centers for Medicare and Medicaid Services. Decision memo for gender dysphoria and gender reassignment surgery (CAG-446n). https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282. Published August 30, 2016. Accessed November 27, 2018.

Wilczynski C, Emanuele MA. Treating a transgender patient: overview of the guidelines. *Postgrad Med*.

2014;126(7):121-128. Doi: 10.3810/pgm.2014.11.2840.

World Professional Association for Transgender Health, Inc. Standard of Care Version 7. https://www.wpath.org/publications/soc. Published September 14, 2011. Accessed November 27, 2018.

World Professional Association for Transgender Health, Inc. Clarification on medical necessity of treatment, sex reassignment, and insurance coverage for transgender and transsexual people worldwide. http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947. Published December 21, 2016. Accessed November 27, 2018.

World Professional Association for Transgender Health, Inc. (WPATH) Clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A. http://www.tgender.net/taw/WPATHMedNecofSRS.pdf. Published June 17, 2008. Accessed November 27, 2018.

Peer-reviewed references:

Ainsworth TA, Spiegel JH. Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Qual Life Res*. 2010;19(7):1019-1024. Doi: 10.1007/s11136-010-9668-7.

Andreasson M, Georgas K, Elander A, Selvaggi G. Patient-reported outcome measures used in gender confirmation surgery: A systematic review. *Plast Reconstr Surg*. 2018;141(4):1026-1039. Doi: 10.1097/PRS.0000000000004254.

Arcelus J, Bouman WP, Van Den Noortgate W, Claes L, Witcomb G, Fernandez-Aranda F. Systematic review and meta-analysis of prevalence studies in transsexualism. *Eur Psychiatry*. 2015;30(6):807-815. Doi: 10.1016/j.eurpsy.2015.04.005.

Asscheman H, Giltay EJ, Megens JA, de Ronde WP, van Trotsenburg MA, Gooren LJ. A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *Eur J Endocrinol*. 2011;164(4):635-642. Doi: 10.1530/EJE-10-1038.

Barone M, Cogliandro A, Di Stefano N, Tambone V, Persichetti P. A Systematic review of patient-reported outcome measures following transsexual surgery. *Aesthetic Plast Surg*. 2017;41(3):700-713. Doi: 10.1007/s00266-017-0812-4.

Bockting WO. Psychotherapy and the real-life experience: from gender dichotomy to gender diversity. *Sexologies*. 2008;17(4):211-224.

Blosnich JR, Brown GR, Wojcio S, Jones KT, Bossarte RM. Mortality among veterans with transgender-

related diagnoses in the Veterans Health Administration, FY2000-2009. *LGBT Health*. 2014;1(4):269-276. Doi: 10.1089/lgbt.2014.0050.

Bouman MB, van Zeijl MC, Buncamper ME, Meijerink WJ, van Bodegraven AA, Mullender MG. Intestinal vaginoplasty revisited: a review of surgical techniques, complications, and sexual function. *J Sex Med*. 2014;11(7):1835-1847. Doi: 10.1111/jsm.12538

Chew D, Anderson J, Williams K, May T, Pang K. Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*. 2018;141(4). Pii: e20173742. Doi: 10.1542/peds.2017-3742.

Colebunders B, Brondeel S, D'Arpa S, Hoebeke P, Monstrey S. An update on the surgical treatment for transgender patients. *Sex Med Rev*. 2017;5(1):103-109. Doi: 10.1016/j.sxmr.2016.08.001.

Costa R, Colizzi M. The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. *Neuropsychiatr Dis Treat*. 2016;12:1953-1966. Doi: 10.2147/NDT.S95310.

Dhejne C, Lichtenstein P, Boman M, Johansson A, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One* 2011;6 (2):e16885. Doi: 10.1371/journal.pone.0016885.

Dhejne C, Öberg K, Arver S, Landén M. An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets. *Arch Sex Behav.* 2014;43(8):1535-1545. Doi: 10.1007/s10508-014-0300-8.

Dreher PC, Edwards D, Hager S, et al. Complications of the neo-vagina in male-to-female transgender surgery: A systematic review and meta-analysis with discussion of management. *Clin Anat*. 2018a;31(2):191-199. Doi: 10.1002/ca.23001.

Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ. A follow-up study of girls with gender identify disorder. *Dev Psychol*. 2008;44(1):34-45. Doi: 10.1037/0012-1649.44.1.34.

Horbach SE, Bouman MB, Smit JM, Ozer M, Buncamper ME, Mullender MG. Outcome of vaginoplasty in male-to-female transgenders: A systematic review of surgical techniques. *J Sex Med*. 2015;12(6):1499-1512. Doi: 10.1111/jsm.12868.

Klein C, Gorzalka BB. Sexual functioning in transsexuals following hormone therapy and genital surgery: a review. *J Sex Med*. 2009;6(11):2922-2939. Doi: 10.1111/j.1743-6109.2009.01370.x.

Knudson G, De Cuypere G, Bockting W. Recommendation for revision of the DSM diagnoses of gender identify disorders: consensus statement of the World Professional Association for Transgender Health. *Int J Transgend*. 2010;12(2):115-118.

Murad MH, Elamin MB, Garcia MZ, et al. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clin Endocrinol (Oxf)*. 2010;72(2):214-231. Doi: 10.1111/j.1365-2265.2009.03625.x.

Rossi Neto R, Hintz F, Krege S, Rubben H, Vom Dorp F. Gender reassignment surgery -- a 13 year review of surgical outcomes. *Int Braz J Urol*. 2012;38(1):97-107.

Selvaggi G, Bellringer J. Gender reassignment surgery: an overview. *Nat Rev Urol*. 2011;8(5):274-282. Doi: 10.1038/nrurol.2011.46.

Sutcliffe PA, Dixon S, Akehurst RL, et al. Evaluation of surgical procedures for sex reassignment: a systematic review. *J Plast Reconstr Aesteth Surg*. 2009;62(3):294-306; discussion 306-308. Doi: 10.1016/j.bjps.2007.12.009.

Van Schallwyk GI, Klingensmith K, Volkmar FR. Gender identity and autism spectrum disorders. *Yale J Biol Med*. 2015;88(1):81-83.

White Hughto JM, Reisner SL. A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgend Health*. 2016;1(1):21-31.

Zucker KJ. Epidemiology of gender dysphoria and transgender identity. *Sex Health*. 2017;14(5):404-411. Doi: 10.1071/SH17067.

Centers for Medicare & Medicaid Services National Coverage Determinations:

140.9 Gender Dysphoria and Gender Reassignment Surgery. A decision memo, not a National Coverage Determination.

Local Coverage Determinations:

No Local Coverage Determinations identified as of the writing of this policy.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

CPT Code	Description	Comment
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	
11951	Subcutaneous injection of filling material (eg, collagen); .1 to 5.0 cc	

CPT Code	Description	Comment
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	
15775	Punch graft for hair transplant: 1 - 15 punch grafts	
15776	Punch graft for hair transplant; more than 15 punch grafts	
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	
15781	Dermabrasion; segmental, face	
15782	Dermabrasion; regional, other than face	
15786	Abrasion, single lesion (eg., keratosis, scar)	
15787	Abrasion; each add'l 4 lesions or less	
15788	Chemical peel, facial; epidermal	
15789	Chemical peel, facial; dermal	
15792	Chemical peel, non-facial; epidermal	
15793	Chemical peel, non-facial; dermal	
15820	Blepharoplasty, lower eyelid	
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad	
15822	Blepharoplasty, upper eyelid	
15823	Blepharoplasty, upper eyelid with extensive 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	
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	
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	
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	
19303	Mastectomy, simple, complete	
19304	Mastectomy, subcutaneous	
19316	Mastopexy	
19324	Mammaplasty, augmentation; without prosthetic implant	
19325	Mammaplasty, augmentation; with prosthetic implant.	

CPT Code	Description	Comment
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.	
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	
19380	Revision of reconstructed breast	
21083	Impression and custom preparation; palatal lift prosthesis	
21087	Impression and custom preparation; nasal prosthesis	
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	
21121	Genioplasty; sliding osteotomy, single piece	
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)	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction; without bone graft	
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction (includes obtaining autografts)	
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autograft); without LeFort I	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autograft); with LeFort I	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts);	

CPT Code	Description	Comment
	without LeFort I	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	
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)	
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	
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	
31750	Tracheoplasty; cervical.	
53430	Urethroplasty, reconstruction of female urethra.	
54120	Amputation of penis; partial	
54125	Amputation of penis; complete.	
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach.	
54660	Insertion of testicular prosthesis (separate procedure).	
54690	Laparoscopy, surgical; orchiectomy.	
55150	Resection of scrotum.	
55175	Scrotoplasty; simple.	
55180	Scrotoplasty; complicated.	
56620	Vulvectomy simple; partial.	

CPT Code	Description	Comment
56625	Vulvectomy simple; complete.	
56800	Plastic repair of introitus.	
56810	Perineoplasty, repair of perineum, nonobstetrical	
57106	Vaginectomy, partial removal of vaginal wall.	
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy).	
57110	Vaginectomy, complete removal of vaginal wall.	
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy).	
57291	Construction of artificial vagina; without graft.	
57292	Construction of artificial vagina; with graft.	
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure).	
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s).	
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), 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).	
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele.	
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele.	
58275	Vaginal hysterectomy, with total or partial vaginectomy.	
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele.	
58290	Vaginal hysterectomy, for uterus greater than 250 g.	
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele.	
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele.	
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less.	
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).	
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g.	
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less.	
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).	
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g.	
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.	

CPT Code	Description	Comment
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy).	
67900	Repair of brow ptosis (supraciliary, mid-forehead, or coronal approach)	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g. banked fascia)	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg., Fasanella-Servat type)	
69300	Otoplasty, protruding ear, with or without size reduction	

ICD-10 Code	Description	Comment
F64.0	Transsexualism	
F64.1	Dual role transvestism	
F64.2	Gender identity disorder of childhood	
F64.8	Other gender identity disorders	
F64.9	Gender identity disorder, unspecified	
Z87.890	Personal history of sex reassignment	

HCPCS Level II Code	Description	Comment
N/A	N/A	