

## MN.010.G Gender Confirmation Surgery

**Original Implementation Date** : 11/6/2016

**Version [G] Date** : 7/18/2024

**Last Reviewed Date**: July 2024

### PRODUCT VARIATIONS

This policy applies to **ALL** Jefferson Health Plans lines of business.

### POLICY STATEMENT

#### COVERED

The surgical treatment of gender confirmation (GC) is only considered medical necessary when **ALL** of the following criteria are met:

1. There must be a referral from a qualified mental health professional and, in accordance with the recommendations from the World Professional Association for Transgender Health (WPATH), the referral letter must include:
  - Assessment of gender identity and gender dysphoria.
  - Diagnosis of gender dysphoria based on DSM-5 requirements.
  - History and development of gender dysphoric feelings.
  - Impact of stigma attached to gender nonconformity on mental health.
  - Availability of support from family, friends, and peers (e.g., in-person or online contact with other transsexual, transgender or gender nonconforming individuals or groups).
  - Psychological readiness for the requested surgeries.
2. Member demonstrates a capacity to make a fully informed decision to consent to treatment
3. The member has been living in the gender role that is congruent with the member's gender identity for a significant period of time.
4. Certain surgeries are only considered medically necessary as set forth below.
  - **Mastectomy.** Mastectomy may be considered medically necessary for female-to-male members when **ALL** the following criteria are met:
    - Assessment performed by a qualified mental health professional result in a diagnosis of gender dysphoria meeting DSM-5 criteria.

- Member demonstrates a capacity to make a fully informed decision to consent to treatment.
- Member is age 18 or older.
  - Consideration will be given to members under the age 18 when:
    - It is preferred however, not mandatory that the member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member’s gender goals (unless hormone therapy is medically contraindicated)
    - Member has completed 12 continuous months of full-time living in a gender role that is congruent with the member’s gender identity.
- Significant medical or mental health concerns are optimally managed and well controlled (if present)
- A referral for mastectomy from a qualified mental health professional has been provided.
- **Augmentation Mammoplasty.** Augmentation Mammoplasty with implantation of breast prostheses may be considered medically necessary for male-to-female members when ALL the following criteria are met:
  - Assessment performed by a qualified mental health professional result in a diagnosis of gender dysphoria meeting DSM-5 criteria.
  - Member demonstrates a capacity to make fully informed decision to consent to treatment.
  - Member is age 18 or older.
    - Consideration will be given to members under the age 18 when:
      - Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member’s gender goals (unless hormone therapy is medically contraindicated),
      - Member has completed 12 continuous months of full-time living in a gender role that is congruent with the member’s gender identity.
  - Significant medical or mental health concerns are optimally managed and well controlled (if present)
  - A referral for augmentation mammoplasty from a qualified mental health professional has been provided.
- **Hysterectomy, Salpingectomy and/or Oophorectomy.** Hysterectomy, salpingectomy and/or oophorectomy may be considered medically necessary for

female-to-male members and orchiectomy may be considered medically necessary for male-to-female members when ALL of the following criteria are met:

- Assessment performed by a qualified mental health professional result in a diagnosis of gender dysphoria meeting DSM-5 criteria.
  - Member demonstrates a capacity to make a fully informed decision and can consent to treatment.
  - Member is age 18 or older.
  - Significant medical or mental health concerns are optimally managed and well controlled (if present)
  - Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role)
  - Referrals for hysterectomy, salpingectomy and/or oophorectomy or orchiectomy have been provided by two qualified mental health professionals who have independently assessed the member (one of these two referrals may be from the qualified mental health professional performing the initial assessment)
- **Genital Reconstructive Surgery.** Genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty with implantation of penile prosthesis and scrotoplasty with insertion of testicular implants for female-to-male members; penectomy, vaginoplasty, vulvoplasty, labiaplasty, and clitoroplasty for male-to-female members) may be considered medically necessary when ALL of the following criteria are met:
- Assessment performed by a qualified mental health professional result in a diagnosis of gender dysphoria meeting DSM-5 criteria.
  - Member demonstrates a capacity to make a fully informed decision to consent to treatment.
  - Member is age 18 or older.
  - Significant medical or mental health concerns are optimally managed and well controlled (if present)
  - Member has completed 12 continuous months of full-time living in a gender role that is congruent with the member's gender identity.
  - Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role)
  - Referrals for genital reconstructive surgery have been provided by two qualified mental health professionals who have independently assessed the

member (one of these two referrals may be from the qualified mental health professional performing the initial assessment).

- **Gender specific services for the transgender community**

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for transmasculine persons who have not undergone chest masculinization surgery.
2. Prostate cancer screening may be medically necessary for transfeminine persons who have retained their prostate.

### **NON-COVERED**

Jefferson Health Plans does not provide coverage for GC surgery when the surgery is not medically necessary for the treatment of gender dysphoria. Examples include, but are not limited to, the following:

1. GC surgery for members who are dissatisfied with their natal sex or prefer to be the opposite sex, without clinically significant distress or impairment resulting in a diagnosis of gender dysphoria meeting DSM-5 criteria.
2. Cosmetic procedures that are generally considered cosmetic include, but are not limited to, body contouring procedures (including abdominoplasty, suction-assisted lipectomy and lipofilling),
3. Rhinoplasty, hair removal, hair transplantation, facial feminization surgery, masculinization surgery and skin resurfacing,)
4. Reversal of GC surgery
5. More than one breast augmentation is considered not medically necessary. This does not include the medically necessary replacement of breast implants.
6. Procedures for the preservation of fertility, including, but not limited to, the procurement, preservation, and storage of sperm, oocytes, or embryos.

## **POLICY GUIDELINES**

In all cases, the appropriate documentation supporting medical necessity must be kept on file and, upon request, presented to Jefferson Health Plans.

The definition of medical necessity may vary by product due to state and federal regulatory requirements.

The determination of medical necessity for GC surgery is based on clinical data including, but not limited to, indicators that would affect the relative risks and benefits of the procedure (e.g., post-operative recovery).

## CODING

*Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.*

*CPT® is a registered trademark of the American Medical Association.*

*View coding table on next page.*

CPT Code	Description
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete.
19304	Mastectomy, subcutaneous
19318	Breast reduction
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
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
31750	Tracheoplasty; cervical
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55150	Resection of scrotum
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55899	Unlisted procedure, male genital system
55970	Intersex surgery, male to female
55980	Intersex surgery, female to male

56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
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; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction of artificial vagina, with graft
57292	Construction of artificial vagina, without graft
57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft, open approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
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 gms or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
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)
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 grams 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 grams; with removal of tube(s) and/or ovary(s)

58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g.
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy).
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral.
58999	Unlisted procedure, female genital system (nonobstetrical)
89258	Cryopreservation; embryo(s)
89335	Cryopreservation, reproductive tissue, testicular
89337	Cryopreservation, mature oocyte(s)
89342	Storage (per year); embryo(s)
89344	Storage (per year); reproductive tissue, testicular/ovarian
89346	Storage (per year); oocyte(s)
89352	Thawing of cryopreserved; embryo(s)
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
89398	Unlisted reproductive medicine laboratory procedure

HCPCS Code	Description
S4030	Sperm procurement and cryopreservation services; initial visit
S4040	Monitoring and storage of cryopreserved embryos, per 30 days

ICD-10 Codes	Description
F64	Gender identity disorders
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

## BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit contract on the date the service was rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

## DESCRIPTION OF SERVICES

Gender Identity Disorder (GID), more commonly known as transsexualism, is a condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-V,), published by the American Psychiatric Association. Transsexualism is also recognized in the ICD Classification of Mental and Behavioral Disorders, tenth revision, as endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as of 1994.

The criteria listed for Gender Identity Disorders (GID) including transsexualism are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity, which is developed in early childhood and understood to be firmly established by age 4, though for some transgender individuals, gender identity may remain somewhat fluid for many years. The ICD 10 descriptive criteria were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment known as gender dysphoria that is often associated with transsexualism.

The World Professional Association for Transgender Health (WPATH) is an international association devoted to the understanding and treatment of individuals with gender identity disorders.

The WPATH Standards of Care for Gender Identity Disorders (Standards of Care), first issued in 1979, articulates the "professional consensus about the psychiatric, psychological, medical and surgical management of GID." Periodically revised to reflect the latest clinical practice and scientific research, the Standards also unequivocally reflect this Association's conclusion that treatment is medically necessary.

The current Board of Directors of the WPATH herewith expresses its conviction that sex (gender) confirmation, properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/or gender dysphoria. Sex confirmation plays an undisputed role in contributing toward favorable outcomes, and comprises Real Life Experience, legal name and sex change on identity documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures. Genital reconstruction is not required for social gender recognition, and such surgery should not be a prerequisite for document or record changes; the Real-Life Experience component of the transition process is crucial to psychological adjustment, and is usually completed prior to any genital reconstruction, when appropriate for the patient, according to WPATH Standards of Care. Changes to documentation are important aids to social functioning and are a necessary component of the pre-surgical process; delay of document changes may have a deleterious impact on a patient's social integration and personal safety.

Medically necessary sex confirmation procedures also include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient (including breast prostheses if necessary), genital reconstruction (by various techniques which must be appropriate to each patient, including, for example, skin flap hair removal, penile and testicular prostheses, as necessary), facial hair removal, and certain facial plastic reconstruction (as appropriate to the patient).

Furthermore, not every patient will have a medical need for identical procedures; clinically appropriate treatments must be determined on an individualized basis with the patient's physician.

The medical procedures attendant to sex confirmation are not "cosmetic" or "elective" or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense but are understood to be medically necessary for the treatment of the diagnosed condition. Further, the WPATH Standards of Care consider it unethical to deny eligibility for sex confirmation surgeries or hormonal therapies solely on the basis of blood seropositivity for infections such as HIV or hepatitis.

These medical procedures and treatment protocols are not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient. For example, a recent study of female-to-male transsexuals found significantly improved quality of life following cross-gender hormonal therapy. Moreover, those who had also undergone chest reconstruction had significantly higher scores for general health, social functioning, as well as mental health.

The WPATH Board of Directors urges state healthcare providers and insurers throughout the world to eliminate transgender or trans-sex exclusions and to provide coverage for transgender patients including the medically prescribed sex confirmation services necessary for their treatment and well-

being, and to ensure that their ongoing healthcare (both routine and specialized) is readily accessible.

## CLINICAL EVIDENCE

N/A

## DEFINITIONS

### GENDER CONFIRMATION SURGERY

**Gender confirmation surgery** is the surgical procedure (or procedures) by which a transgender person's physical appearance and function of their existing sexual characteristics are altered to resemble that socially associated with their identified gender. It is part of a treatment for gender dysphoria in transgender people.

### GENDER DYSPHORIA

**Gender Dysphoria:** (1) Discontent with the physical or social aspects of one's own sex. (2) In *DSM-5*, a diagnostic class that replaces gender identity disorder and shifts clinical emphasis from cross-gender identification itself to a focus on the possible distress arising from a sense of mismatch, or incongruence, that one may have about one's experienced gender versus one's assigned gender. Diagnostic criteria for gender dysphoria in children include significant distress or impairment due to marked gender incongruence, such as a strong desire to be-or a belief that one is-the other gender; preference for the toys, games, roles, and activities stereotypically associated with the other gender, and a strong dislike of one's sexual anatomy. In adults, the manifestations of gender dysphoria may include a strong desire to replace one's physical sex characteristics with those of the other gender (see *SEX REASSIGNMENT*), the belief that one has the emotions of their gender, and a desire to be treated as the other gender or recognized as having an alternative gender identity.

### QUALIFIED MENTAL HEALTH PROFESSIONAL

**Qualified Mental Health Professional:** A mental health professional who diagnoses and treats adults presenting for care regarding their gender identity or gender dysphoria and who possess the following minimum credentials, as recommended in the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7:1

1. A master's degree or equivalent in a clinical behavioral science field from an institution accredited by the appropriate national accrediting board and is licensed by the relevant licensing board to practice in the Commonwealth of Pennsylvania.
2. Competence in using the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders for diagnostic purposes.

3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria. Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
5. Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

## DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by Jefferson Health Plans to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

Per DHS Medicaid and CHIP products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

## POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
July 2024 ad-hoc review. Product variation section updated to include coverage for all Jefferson Health Plans lines of business.	G	7/18/2024
2024 Annual review. CPT code 19318 (Breast reduction) was added to the coding table.	F	5/15/2024
2023 Annual review. Minor change. Nipple reconstruction removed from non-covered section.	E	5/1/2022
2022 Annual review. Added to covered services: Gender specific services for the transgender community. Added to	E	5/1/2022

Non-Covered services: More than one breast augmentation		
2021 Annual review. The following was added to the non-covered section of the policy: facial feminization surgery, masculinization surgery, procedures for the preservation of fertility. The following codes were added to the coding table: 89258, 89335, 89337, 89342, 89344, 89346, 89352, 89354, 89398, S4030 & S4040.	D	7/1/2021
2020 Annual review. Language was added to the policy statement to enhance readability.	C	9/1/2020
2019 Annual review. No revisions to this version.	B	7/18/2018
2018- Modifications made to enhance readability and clarify intent, including addition of definitions. New codes added.	B	7/18/2018
New policy.	A	11/6/2016

## REFERENCES

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10. Wikipedia (Gender confirmation surgery definition):  
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11. 2018 American Psychological Association (Gender Dysphoria definition):  
<https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>