Clinical Policy: Gender Reassignment Surgery

Reference Number: CP.MP.HN 496
Effective Date: 11/09
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Services for gender reassignment most often include hormone treatment, counseling, psychotherapy, complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate, genital reconstruction, facial hair removal, and certain facial plastic reconstruction. Not every individual will require each intervention so necessity needs to be considered on an individualized basis. These criteria outline medical necessity criteria for gender reassignment surgery *when such services are included under the members' benefit plan contract provisions and subject to applicable state and federal laws*. This policy is based on recommendations from the World Professional Association of Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association, Standards of Care For Gender Identity Disorders, 7th version.

Policy/Criteria
It is the policy of Health Net of California that the gender reassignment surgeries listed in section III are considered **medically necessary** for members when diagnosed with gender dysphoria per criteria in section I and when meeting the eligibility criteria in section II

I. Marked incongruence between the member's experienced/expressed gender and assigned gender and has experienced the following:

- The individual is participating in a recognized gender identity treatment program
- The individual has the desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment, and
- The transsexual identity has been present persistently for at least two years, and
- The disorder is not a symptom of another mental disorder, and
- The individual should be knowledgeable regarding cost, required lengths of hospitalizations, likely complications, and post-surgical rehabilitation requirements of various surgical approaches, and
- The individual has obtained the appropriate letters of referral noted in Referral Letters section.

II. Eligibility Criteria meets all

A. Age ≥ 18
   a. Exception: in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment;

B. Persistent, well-documented gender dysphoria with evidence the member has lived at least 12 continuous months in a gender role that is congruent with their gender identity (not required for mastectomy in female to male except for those < 18 years);

C. Capacity to make a fully informed decision and to consent for treatment;

D. If significant medical or mental health concerns are present, they must be reasonably well controlled;

E. Written referral letter(s) from a qualified mental health practitioner (See below for qualifications) based on the type of surgery (one referral for chest surgery; two referrals for genital surgery) and containing the following:
   1. The client's general identifying characteristics;
   2. Results of the client's psychosocial assessment, including any diagnoses;
   3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
   4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
   5. A statement about the fact that informed consent has been obtained from the patient;
   6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.
   7. The degree to which the member has followed the standards of care to date and the likelihood of future compliance
   8. For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

*Qualified Mental Health Professionals
Transsexual, transgender, and gender-nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health

counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling.

The following are minimum requirements for mental health professionals who work with individuals with gender dysphoria, or who provide consultative evaluations for gender reassignment surgery:

1. Psychiatrist or clinical psychologist (Master's level minimum with Ph.D. or Psy.D. preferred) or non-psychiatrist MD/DO with documented extensive clinical experience in gender dysphoria comparable to the credentialed requirement. These degrees should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented active licensure from a relevant licensing board.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.
3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
5. Knowledgeable 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.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

III. Gender reassignment surgeries considered medically necessary when meeting above criteria:

A. Procedures for transwomen (male to female) include:

- Orchiectomy
- Penectomy
- Vaginoplasty
- Urethroplasty
- Mammaplasty
- Clitoroplasty
- Labiaplasty

Note: Although not an explicit criterion, it is recommended that male to female individuals undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

B. Procedures for transmen (female to male) include:
- Mastectomy
- Salpingo-oophorectomy
- Vaginectomy
- Vulvectomy
- Metoidoplasty
- Phalloplasty
- Hysterectomy
- Urethroplasty
- Scrotoplasty
- Testicular prosthesis

IV Medically Necessary/Reconstructive Surgery

A. It is the policy of Health Net of California that each of the following procedures, when used specifically to improve the appearance of an individual undergoing gender reassignment surgery or actively participating in a documented gender reassignment surgery treatment plan, must be evaluated to determine if it is medically necessary reconstructive surgery to create a normal appearance for the gender with which the member identifies. Prior to making a clinical determination of coverage, it may be necessary to consult with a qualified and licensed mental health professional and the treating surgeon.
    - Abdominoplasty
    - Breast augmentation
    - Subcutaneous mastectomy
    - Blepharoplasty
    - Electrolysis*
    - Facial feminization
    - Facial bone reduction
    - Hair transplantation
    - Hair removal
    - Liposuction
    - Reduction thyroid chondroplasty
    - Rhinoplasty
    - Voice modification surgery

The above section clarifies how the plan administers benefits in accordance with the WPATH, SOC, Version 7. Provided a patient has been properly diagnosed with gender dysphoria or GID by a mental health professional or other provider type with appropriate training in behavioral health and competencies to conduct an assessment of gender dysphoria or GID, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy, certain options for social support and changes in gender expression are considered to help alleviate gender dysphoria or GID.

For example, with respect to hair removal through electrolysis, laser treatment, or waxing, the WPATH "Statement of Medical Necessity for Electrolysis" (July 15, 2016) clarifies that patients with the same condition do not always respond to, or thrive, following the application of identical treatments. Treatment must be individualized, such as with electrolysis, and medical necessity should be determined according to the judgment of a qualified mental health professional and the referring physician.

The documentation to support the medical necessity for hair removal should include all three essential elements:

- A properly trained (in behavioral health) and competent (in assessment of gender dysphoria) professional has diagnosed the member with gender dysphoria or GID.
- The individual has completed 3 years of feminizing hormonal therapy.
- The medical necessity for electrolysis has been determined according to the judgment of a qualified mental health professional and the referring physician.

If any element remains to be satisfied before medical necessity can be determined, the individual should be directed to an appropriate network participating provider for consultation or treatment.

V. Hormone Therapy (Based on WPATH version 7 recommendations)

It is the policy of Health Plans affiliated with Centene Corporation® that the administration of exogenous endocrine agents to induce feminizing or masculinizing changes is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria. Hormone therapy is individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria.

A. **Adolescents:** Adolescents may be eligible for puberty-suppressing hormones as soon as pubertal changes have begun. In order for adolescents to receive puberty suppressing hormones, WPATH recommends that the following minimum criteria must be met:
   1. The adolescent experienced the onset of puberty to at least Tanner Stage 2 prior to the initiation of hormone therapy;
   2. The adolescent has demonstrated a long lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
   3. Gender dysphoria emerged or worsened with the onset of puberty;

4. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
5. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
6. Adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action.
7. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

B. **Adults:** Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults. Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional. Feminizing/masculinizing hormone therapy produces physical changes that are more congruent with a patient's gender identity. Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. The criteria for hormone therapy are as follows:
    1. Persistent, well-documented gender dysphoria;
    2. Capacity to make a fully informed decision and to consent for treatment;
    3. If significant medical or mental health concerns are present, they must be reasonably well-controlled
    4. No contraindications to feminizing hormones especially estrogen including previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease.

Background

Gender identity is a person's deepest inner sense of being female or male, which for many is established by the age of 2 – 3 years. *Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to the discomfort or distress that is cause 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) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only some transsexual, transgender, and gender-nonconforming people experience gender dysphoria at some point in their lives.

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Gender Reassignment Surgery

Treatment to assist people with gender dysphoria is available and can help to find the gender identity and role that is comfortable for them. Treatment is very individualized and may or may not involve gender reassignment surgery or body modification. Treatment options include changes in gender expression and role; hormone therapy to feminize or masculinize the body; surgery to change primary and/or secondary sex characteristics; and psychotherapy. Many people who receive treatment for gender dysphoria will find a gender role and expression that is comfortable for them, regardless if they differ from the sex assigned them at birth.

The World Professional Association of Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, (HBIGDA) was founded in 1979. The organization, devoted to the understanding and treatment of GIDs, consists of over 300 physicians, psychologists, social scientists, and legal professional members, all of whom are engaged in research and/or clinical practice that affects the lives of transgeneder and transsexual people. WPATH has established internationally accepted Standards of Care (SOC) for the treatment of gender identity disorders. These internationally accepted guidelines are designed to promote the health and welfare of persons with gender identity disorders and are used as a reference in this policy. The Standards of Care are updated and revised as new scientific information becomes available.

Hormone Therapy
For masculinizing hormone therapy (female to male), the most commonly prescribed masculinizing hormone is intramuscular testosterone administered every 2–4 weeks. Other agents such as progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality

In female to male patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, and decreased percentage of body fat compared to muscle mass. Contraindications to masculinizing hormones therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher. Consideration must be given to patients with a history of breast or other estrogen-dependent cancers, since the aromatization of testosterone to estrogen may increase risk in these patients.

Commonly prescribed feminizing (male to female) hormone medications include oral estrogen and androgen-reducing medications (anti-androgens). A combination of estrogen and “anti-androgens” is the most commonly studied regimen for feminization. Androgen-reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity and, thus, diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone thereby reducing the risks associated with high-dose exogenous estrogen. Examples include:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.
- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin-releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. These medications are only available as injectables or implants.
- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5- alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.
- Cyproterone acetate (i.e. *Androcur®)* is a progestational compound with anti-androgenic properties. This medication is not commercially available in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere.
- Progestins (such as medroxyprogesterone such as Provera) use is controversial because of the potential adverse effects including depression, weight gain, and lipid changes and they are also suspected to increase breast cancer risk and cardiovascular risk in women. Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does

In male to female patients, physical changes such as breast growth (variable), decreased erectile function, decreased testicular size, and increased percentage of body fat compared to muscle mass are expected to occur The risks of adverse events associated with feminizing/ masculinizing hormone therapy are dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, comorbidities, family history, and health habits). Feminizing hormones can cause increases in venous thromboembolic disease, gallstones, elevated liver enzymes, weight gain and hypertriglyceridemia and cardiovascular disease. Masculinizing hormones may increase the risk of polycythemia, weight gain, acne, androgenic alopecia (balding) and sleep apnea.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes that may be considered part of gender reassignment surgery.

CLINICAL POLICY
Gender Reassignment Surgery

This code list does not indicate if a procedure is or is not considered medically necessary.

CPT®* Codes	Description
11950-11954	Subcutaneous injection of filling material (eg, collagen)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14040	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm etc
15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15600	Delay of flap or sectioning of flap (division and inset); at trunk
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780-15783	Dermabrasion
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820-15823	Blepharoplasty

CPT®* Codes	Description
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832-15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876-15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19300	Mastectomy for gynecomastia
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, 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)
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)
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)

CPT®* Codes	Description
31580	Laryngoplasty; for laryngeal web, 2-stage, with keel insertion and removal
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type)
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
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
54125	Amputation of penis; complete
54340	Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple
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
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach

CPT®* Codes	Description
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
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
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal 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 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
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
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
58285	Vaginal hysterectomy, radical (Schauta type operation)
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)

CPT®* Codes	Description
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58293	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
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)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
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)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58999	Unlisted procedure, female genital system (nonobstetrical)
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F64-F64.9	Gender identity disorder
Z87.890	Personal history of sex reassignment

CLINICAL POLICY
Gender Reassignment Surgery

Reviews, Revisions, and Approvals	Date	Approval Date
Medical Advisory Council, initial approval		11/09
Added Medicare table, no other changes		2/11
Update – no revisions		2/12
Updated coding, no revisions		2/13
Revised format, removed "chromosomal abnormalities" from policy statement, revised hormone therapy requirements, clarified Letters of Recommendation		6/13
Added section on Hormone Therapy		2/14
Removed website on Medicare NCD on Transsexual Surgery. Per Medicare notice, NCD 140.3 was removed June 27, 2014. Additionally, references to transsexual surgery have been removed from Pub. 100-02, Medicare Benefit Policy Manual. Because the NCD is no longer valid as of the effective date, its provisions are no longer a basis for denying claims for Medicare coverage of "transsexual surgery" under 42 CFR §405.1060.		8/14
Under Not Medically Necessary, added instructions to review member coverage documents and state mandates for coverage guidance		11/14
Update - No revisions as of date of this update as it is based on the most current WPATH Version 7		6/15
Section added "Qualified Mental Health Professionals" to define qualifications		5/16
Revised section "Not Medically Necessary or Cosmetic Procedures'" to "Medically Necessary or Reconstructive Surgery" to note clinical determination for coverage considerations		8/16
Clarified administration of benefits in Medically Necessary or Reconstructive Surgery section. Added subcutaneous mastectomy. Added codes		9/16
Revised section on electrolysis requiring 3 years of hormonal therapy		1/17
Revised section II A under 18: Exception: in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment; and under B (not required for mastectomy in female to male except for those < 18 years) based on the Centene corporate policy	11/17	12/17

Bibliography

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.