# Gender Dysphoria Treatment (for Pennsylvania Only)

**Policy Number**: CS145PA.L
**Effective Date**: March 1, 2023

Instructions for Use

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**Related Policies**

- Botulinum Toxins A and B
- Brow Ptosis and Eyelid Repair (for Pennsylvania Only)
- Cosmetic and Reconstructive Procedures (for Pennsylvania Only)
- Gonadotropin Releasing Hormone Analogs
- Habilitation and Rehabilitation Therapy (Occupational, Physical and Speech) (for Pennsylvania Only)
- Panniculectomy and Body Contouring Procedures (for Pennsylvania Only)
- Rhinoplasty and Other Nasal Surgeries (for Pennsylvania Only)

## Application

This Medical Policy only applies to the state of Pennsylvania. Any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis. Refer to Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101.

## Coverage Rationale

See Benefit Considerations

**Note**: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development.

In determining medical necessity for gender confirmation services, Pennsylvania will utilize the World Professional Association for Transgender Health (WPATH) Standard of Care as guidelines and any successor WPATH guidelines to determine whether the services are medically necessary. Current Standard of Care guidelines can be found here: https://www.wpath.org/publications/soc. For additional information, refer to the Managed Care Operations Memorandum Coverage of Services Related to Gender Transition MCOPS Memo # 07/2016-007.

**Gender Confirmation Surgical treatment for Gender Dysphoria may be indicated for individuals who provide the following documentation**:

- For breast surgery, a written psychological assessment from at least one Qualified Behavioral Health Provider experienced in treating Gender Dysphoria* is required. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.


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- Must be at least 18 years of age (age of majority*). For individuals 17 and younger, refer to the Standard of Care for children and adolescents (World Professional Association for Transgender Health [WPATH] Guidelines, version 7, 2012).
- Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges.
- Although not an explicit criterion, it is recommended that male to female members 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.

  * Chest surgery in female to male members could be requested earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

- For genital surgery, a written psychological assessment from at least two Qualified Behavioral Health Providers experienced in treating Gender Dysphoria*, who have independently assessed the individual, is required. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be at least 18 years of age (age of majority).
  - Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges.
  - Complete at least 12 months of successful continuous full-time real-life involvement in the experienced gender.
  - Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated).
- Treatment plan that includes ongoing follow up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria.

**When the above criteria are met, the following Gender Confirmation surgical procedures to treat Gender Dysphoria are medically necessary and covered as a proven benefit**:

- Bilateral mastectomy or breast reduction*
- Breast enlargement, including augmentation mammaplasty and breast implants, in male to female members
- Clitoroplasty (creation of clitoris)
- Hysterectomy (removal of uterus)
- Labiaplasty (creation of labia)
- Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria
- Mastopexy in male to female members
- Metoidioplasty (creation of penis, using clitoris)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prostheses
- Urethroplasty (reconstruction of female urethra)
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vaginoplasty (creation of vagina)
- Vulvectomy (removal of vulva)

*When bilateral mastectomy or breast reduction is performed as a stand-alone procedure, without genital reconstruction procedures, completion of hormone therapy prior to the breast procedure is not required.


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**Certain ancillary procedures, including but not limited to the following, may be considered cosmetic and not medically necessary when performed as part of surgical treatment for Gender Dysphoria.** Items identified as cosmetic must be reviewed on a case-by-case basis as they could be considered medically necessary for individuals with severe gender dysphoria):

- Abdominoplasty (also refer to the Medical Policy titled Panniculectomy and Body Contouring Procedures (for Pennsylvania Only))
- Blepharoplasty (also refer to the Medical Policy titled Brow Ptosis and Eyelid Repair (for Pennsylvania Only))
- Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also refer to the Medical Policy titled Panniculectomy and Body Contouring Procedures (for Pennsylvania Only))
- Brow lift
- Calf implants
- Cheek, chin and nose implants
- Face/forehead lift and/or neck tightening
- Facial bone remodeling for facial feminization
- Hair transplantation
- Injection of fillers or neurotoxins (also refer to the Medical Benefit Drug Policy titled Botulinum Toxins A and B)
- Laser or electrolysis hair removal not related to genital reconstruction
- Lip augmentation
- Lip reduction
- Liposuction (suction-assisted lipectomy) (also refer to the Medical Policy titled Panniculectomy and Body Contouring Procedures (for Pennsylvania Only))
- Pectoral implants for chest masculinization
- Rhinoplasty (also refer to the Coverage Determination Guideline titled Rhinoplasty and Other Nasal Surgeries (for Pennsylvania Only))
- Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
- Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
- Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords)
- Voice lessons and voice therapy

# Definitions

**Gender Dysphoria in Adolescents and Adults**: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision [DSM-5- TR™]):

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

**Gender Dysphoria in Children**: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision [DSM-5- TR™]):

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least six** of the following (**one of which must be criterion A1**):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)


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- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
  - 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
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities
  - A strong dislike of ones' sexual anatomy
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

**Qualified Behavioral Health Provider:**

- Recommended minimum credentials for behavioral health providers working with adults presenting with gender dysphoria (World Professional Association for Transgender Health [WPATH] Guidelines, version 7, 2012):
  - A minimum of a master's degree or its equivalent in a clinical behavioral science field. This degree should be granted by an institution accredited by the appropriate national or regional accrediting board. The behavioral health provider should have documented credentials from a relevant licensing board;
  - Competence in using the current version of the Diagnostic Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD) for assessment and diagnostic purposes;
  - Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria;
  - Documented supervised training and competence in psychotherapy or counseling;
  - Knowledgeable about gender nonconforming identities and expressions, and the evaluation and treatment of gender dysphoria;
  - Continuing education in the assessment and treatment of gender dysphoria;
  - Develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients
- Recommended minimum credentials for behavioral health providers working with children or adolescents presenting with gender dysphoria (WPATH Guidelines, version 7, 2012):
  - Meet the competency requirements for behavioral health providers working with adults, as outlined above;
  - Trained in childhood and adolescent developmental psychopathology;
  - Competent in diagnosing and treating the ordinary problems of children and adolescents

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description |
|---|---|
| 11950 | Subcutaneous injection of filling material (e.g., collagen); 1 cc or less |
| 11951 | Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc |
| 11952 | Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc |
| 11954 | Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc |
| 14000 | Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less |
| 14001 | 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 |


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| CPT Code | Description |
|---|---|
| 15734 | Muscle, myocutaneous, or fasciocutaneous flap; trunk |
| 15738 | Muscle, myocutaneous, or fasciocutaneous flap; lower extremity |
| 15750 | Flap; neurovascular pedicle |
| 15757 | Free skin flap with microvascular anastomosis |
| 15758 | Free fascial flap with microvascular anastomosis |
| 15769 | Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia) |
| 15771 | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate |
| 15772 | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) |
| 15773 | Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate |
| 15774 | Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure) |
| 15775 | Punch graft for hair transplant; 1 to 15 punch grafts |
| 15776 | Punch graft for hair transplant; more than 15 punch grafts |
| 15780 | Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis) |
| 15781 | Dermabrasion; segmental, face |
| 15782 | Dermabrasion; regional, other than face |
| 15783 | Dermabrasion; superficial, any site (e.g., tattoo removal) |
| 15788 | Chemical peel, facial; epidermal |
| 15789 | Chemical peel, facial; dermal |
| 15792 | Chemical peel, nonfacial; epidermal |
| 15793 | Chemical peel, nonfacial; dermal |
| 15819 | Cervicoplasty |
| 15820 | Blepharoplasty, lower eyelid |
| 15821 | Blepharoplasty, lower eyelid; with extensive herniated fat pad |
| 15822 | Blepharoplasty, upper eyelid |
| 15823 | Blepharoplasty, upper eyelid; with excessive 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 |
| 15829 | Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap |
| 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 |


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| CPT Code | Description |
|---|---|
| 15838 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad |
| 15839 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area |
| 15847 | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure) |
| 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 |
| 17999 | Unlisted procedure, skin, mucous membrane and subcutaneous tissue |
| 19303 | Mastectomy, simple, complete |
| 19316 | Mastopexy |
| 19318 | Breast reduction |
| 19325 | Breast augmentation with implant |
| 19340 | Insertion of breast implant on same day of mastectomy (i.e., immediate) |
| 19342 | Insertion or replacement of breast implant on separate day from mastectomy |
| 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 (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) |
| 21139 | Reduction forehead; contouring and setback of anterior frontal sinus wall |
| 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 (e.g., 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) |
| 21270 | Malar augmentation, prosthetic material |
| 21899 | Unlisted procedure, neck or thorax |


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| CPT Code | Description |
|---|---|
| 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) |
| 31599 | Unlisted procedure, larynx |
| 31899 | Unlisted procedure, trachea, bronchi |
| 53410 | Urethroplasty, 1-stage reconstruction of male anterior urethra |
| 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 |
| 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 |
| 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 |
| 57110 | Vaginectomy, complete removal of vaginal wall |
| 57335 | Vaginoplasty for intersex state |


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| CPT Code | Description |
|---|---|
| 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) |
| 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 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 |
| 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) |
| 58940 | Oophorectomy, partial or total, unilateral or bilateral |
| 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) |
| 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual |
| 92508 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals |

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| Diagnosis Code | Description |
|---|---|
| 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 |


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| Diagnosis Code | Description |
|---|---|
| Z87.890 | Personal history of sex reassignment |

# Description of Services

Gender Dysphoria is a condition in which there is a marked incongruence between an individual's experienced/expressed/alternative gender and assigned gender (DSM-5- TR). Treatment options include behavioral therapy, psychotherapy, hormone therapy and surgery for gender transformation. Surgical treatments for gender dysphoria may include the following: clitoroplasty, hysterectomy, labiaplasty, mastectomy, orchiectomy, penectomy, phalloplasty or metoidioplasty (alternative to phalloplasty), placement of testicular and/or penile prostheses, salpingo-oophorectomy, scrotoplasty, urethroplasty, urethroplasty, vaginectomy, vaginoplasty and vulvectomy.

Other terms used to describe surgery for gender dysphoria include gender affirming surgery, sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery, and sex reassignment.

# Benefit Considerations

## Coverage Information

Benefit coverage for health services is determined by the federal, state or contractual requirements that may require coverage for a specific service.

Unless otherwise specified, if a plan covers treatment for Gender Dysphoria, coverage includes psychotherapy, hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments listed in the Coverage Rationale section. Refer to the Drug Policy titled Gonadotropin Releasing Hormone Analogs.

## Limitations and Exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatment received outside of the United States
- Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or Gender Dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus (refer to the federal, state or contractual requirements for benefit coverage)
- Transportation, meals, lodging or similar expenses
- Cosmetic procedures (see Medical Policy titled Cosmetic and Reconstructive Procedures (for Pennsylvania Only) and the Coverage Rationale section)
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

Coverage does not apply to members who do not meet the indications listed in the Coverage Rationale section above.

# Clinical Evidence

Almazan et al (2021) conducted a secondary analysis of the 2015 United States Transgender Survey (USTS) that included 27,715 transgender and gender diverse (TGD) people to evaluate whether gender-affirming surgeries were associated with better mental health outcomes including psychological distress, substance use and suicide risk when compared to TGD people who do not undergo gender-affirming surgeries. The survey was conducted across all 50 states, Washington, DC, US territories and US military bases abroad. The exposure group included respondents who indicated they had undergone 1 or more gender-affirming surgeries at least 2 years prior to submitting survey responses. This group was compared to respondents who indicated a desire to undergo 1 or more types of gender-affirming surgeries but denied having had any gender-affirming surgeries. Of the 27,715 respondents, 3,559 (12.8%) indicated they had undergone 1 or more gender-affirming surgeries at least 2 years prior to the survey while 59.2% (n = 16,401) indicated a desire to undergo a gender-affirming surgery but had not done so as of the time they responded to the survey. Demographics of the respondents to the survey showed that 81.1% (n = 16,182) were between the ages of 18 and 44 years, 82.1% (n = 16,386) identified as white, 38.8% (n = 7,751) identified as transgender women, 32.5% (n = 6489) identified as transgender men and 26,6% (n = 5,300) identified as nonbinary. After


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adjusting for sociodemographic factors, the authors concluded that the analysis showed TGD people with a history of gender-affirming surgery had significantly lower odds of past-month psychological distress, past-year tobacco smoking, and past-year suicidal ideation compared with TGD people who did not have any gender-affirming surgery. Limitations noted by the authors included the nonprobability sampling of the database, the self-reporting structure of the measures, and the risk of confounding. The authors concluded that the study showed a positive association between gender-affirming surgery and improved mental health outcomes for TGD people who seek gender affirming surgical interventions.

Scandurra et al. (2019) performed a systematic review assessing the health of nonbinary and genderqueer (NBGQ) individuals compared to binary transgender (BT) and cisgender individuals. Eleven studies were included in the review. Results related to the difference in health between NBGQ and BT were mixed, with some finding a better health status while others a worse one. Results related to the differences in health between NBGQ and cisgender individuals highlighted higher health needs in NBGQ individuals compared with cisgender counterparts. The authors noted the need for research expansion in terms of both methodology and research contents.

Wernick et al. (2019) conducted a systematic review of the psychological benefits of gender-affirming surgery. Thirty-three studies were included in the analysis. Overall, most of the studies comparing pre- and post-operative data on quality of life, body image/satisfaction, and overall psychological functioning among individuals with gender dysphoria suggested that gender-affirming surgery leads to multiple, significant psychological benefits. Of the studies comparing psychological well-being between individuals who did or did not undergo surgery, most demonstrated a trend of better mental health among individuals who underwent surgery compared with those who did not. The authors encouraged future research to focus on standardizing the assessment of psychological functioning pre- and post-gender-affirming surgery to gather longitudinal data that will allow for more definitive conclusions to be made about factors that contribute to the psychological benefits of surgery.

Cohen et al. (2019) conducted a systematic review of surgical options and associated outcomes for transmasculine top surgery. Twenty-two studies were included (n = 2447). The authors reported that future research is needed to improve patient selection, surgical decision making, and patient-reported outcomes for different chest contouring techniques.

Mahfouda et al. (2019) conducted a systematic review of the available published evidence on gender-affirming hormone and surgical interventions in transgender children and adolescents, amalgamating findings on mental health outcomes, cognitive and physical effects, side-effects, and safety variables. The small amount of available data suggests that when clearly indicated in accordance with international guidelines, gender-affirming hormone therapy and chest wall masculinization in transgender males are associated with improvements in mental health and quality of life. Evidence regarding surgical vaginoplasty in transgender females younger than age 18 years remains extremely scarce and conclusions cannot yet be drawn regarding its risks and benefits in this age group. Further research on an international scale is urgently warranted to clarify long-term outcomes on psychological functioning and safety.

A Hayes report on sex reassignment surgery (2018; updated 2021) for the treatment of gender dysphoria made the following conclusions:

- Studies suggest that following sex reassignment surgery, patients reported decreased gender dysphoria and improved body image satisfaction. However, results were mixed regarding effects of sex reassignment surgery on quality of life and psychological symptoms.
- Few studies compare outcomes in patients who received sex reassignment surgery with stand-alone hormone therapy. The results of these studies suggest that sex reassignment surgery may improve gender dysphoria, quality of life, body image and psychological symptoms to a greater extent than hormone therapy alone. However, the results were conflicting.
- Few studies compared outcomes in patients who received different components of sex reassignment surgery. For most outcome measures, there was only a single study available. This evidence is therefore insufficient to support definitive conclusions regarding the comparative effectiveness of different components of sex reassignment surgery for treating gender dysphoria.
- Not all studies reported all outcomes; the following findings therefore do not inform overall incidence of complications. Following sex reassignment surgery, there were very low rates of regret of surgery (0% to 6% per study) and suicide (2% to 3% per study). Complications following sex reassignment surgery were common, and some were serious.

Dreher et al. (2018) conducted a systematic review and meta-analysis to evaluate the epidemiology, presentation, management, and outcomes of neovaginal complications in the MtF transgender reassignment surgery patients. Selected studies reported on 1,684 patients with an overall complication rate of 32.5% and a reoperation rate of 21.7% for non-esthetic reasons. The most


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common complication was stenosis of the neo-meatus (14.4%). Wound infection was associated with an increased risk of all tissue-healing complications. Use of sacrospinous ligament fixation (SSL) was associated with a significantly decreased risk of prolapse of the neovagina. The authors concluded that gender-affirmation surgery is important in the treatment of gender dysphoric patients, but there is a high complication rate in the reported literature. Variability in technique and complication reporting standards makes it difficult to assess the accurately the current state of MtF gender reassignment surgery. Further research and implementation of standards is necessary to improve patient outcomes.

Manrique et al (2018) conducted a systematic review of retrospective studies on the outcomes of MtF vaginoplasty to minimize surgical complications and improve patient outcomes for transgender patients. Forty-six studies met the authors eligibility criteria. A total of 3716 cases were analyzed. The results showed the overall incidence of complications as follows: 2% fistula, 14% stenosis and strictures, 1% tissue necrosis, and 4% prolapse. Patient-reported outcomes included a satisfaction rate of 93% with overall results, 87% with functional outcomes, and 90% with esthetic outcomes. Ability to have orgasm was reported in 70% of patients. The regret rate was 1%. The authors concluded that multiple surgical techniques have demonstrated safe and reliable means of MtF vaginoplasty with low overall complication rates and with a significant improvement in the patient's quality of life. Studies using different techniques in a similar population and standardized patient-reported outcomes are required to further analyze outcomes among the different procedures and to establish best-practice guidelines.

Van Damme et al. (2017) conducted a systematic review of the effectiveness of pitch-raising surgery performed in MtF transsexuals. Twenty studies were included: eight using cricothyroid approximation, six using anterior glottal web formation and six using other surgery types or a combination of surgical techniques. A substantial rise in postoperative frequency was identified. The majority of patients seemed satisfied with the outcome. However, none of the studies used a control group and randomization process. Further investigation regarding long-term results using a stronger study design is necessary.

Gaither et al. (2017) retrospectively reviewed the records of 330 MtF patients from 2011 to 2015, to assess surgical complications related to primary penile inversion vaginoplasty. Complications included granulation tissue, vaginal pain, wound separation, labial asymmetry, vaginal stenosis, fistula formation, urinary symptoms including spraying stream or dribbling, infection, vaginal fissure or vaginal bleeding. Median age at surgery was 35 years, and median follow up in all patients was 3 months. The results showed that 95 of the patients presented with a postoperative complication with the median time to a complication being 4.4 months. Rectoneovaginal fistulas developed in 3 patients, and 30 patients required a second operation. Age, body mass index and hormone replacement therapy were not associated with complications. The authors concluded that penile inversion vaginoplasty is a relatively safe procedure. Most complications due to this surgery develop within the first 4 months postoperatively. Age, body mass index and hormone replacement therapy are not associated with complications and, thus, they should not dictate the timing of surgery.

An ECRI special report systematically reviewed the clinical literature to assess the efficacy of treatments for gender dysphoria. The authors identified limited evidence from mostly low-quality retrospective studies. Evidence on gender reassignment surgery was mostly limited to evaluations of MtF individuals undergoing vaginoplasty, facial feminization surgery and breast augmentation. Outcomes included mortality, patient satisfaction, physical well-being, psychological-related outcomes, quality of life, sexual-related outcomes, suicide and adverse events. Concluding remarks included the need for standardized protocols and prospective studies using standardized measures for correct interpretation and comparability of data (ECRI, 2016).

Morrison et al. (2016) conducted a systematic review of the facial feminization surgery literature. Fifteen studies were included, all of which were either retrospective or case series/reports. The studies covered a variety of facial feminization procedures. A total of 1121 patients underwent facial feminization surgery, with seven complications reported, although many studies did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors noted that further studies are needed to better compare different techniques to more robustly establish best practices. Prospective studies and patient-reported outcomes are needed to establish quality of life outcomes for patients.

Frey et al. (2016) conducted a systematic review of metoidioplasty and radial forearm flap phalloplasty (RFFP) in FtM transgender genital reconstruction. Eighteen studies were included: 7 for metoidioplasty and 11 for RFFP. The quality of evidence was low to very low for all included studies. In studies examining metoidioplasty, the average study size and length of follow up were 54 patients and 4.6 years, respectively (1 study did not report [NR]). Eighty-eight percent underwent a single-stage reconstruction, 87% reported an aesthetic neophallus (3 NR) and 100% reported erogenous sensation (2 NR). Fifty-one percent of patients reported successful intercourse (3 NR) and 89% of patients achieved standing micturition (3 NR). In studies


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examining RFFP, the average study size and follow up were 60.4 patients and 6.23 years, respectively (6 NR). No patients underwent single-stage reconstructions (8 NR). Seventy percent of patients reported a satisfactorily aesthetic neophallus (4 NR) and 69% reported erogenous sensation (6 NR). Forty-three percent reported successful penetration of partner during intercourse (6 NR) and 89% achieved standing micturition (6 NR). Compared with RFFP, metoidioplasty was significantly more likely to be completed in a single stage, have an aesthetic result, maintain erogenous sensation, achieve standing micturition and have a lower overall complication rate. The authors reported that, although the current literature suggests that metoidioplasty is more likely to yield an "ideal" neophallus compared with RFFP, any conclusion is severely limited by the low quality of available evidence.

Using a retrospective chart review, Buncamper et al. (2016) assessed surgical outcome after penile inversion vaginoplasty. Outcome measures were intraoperative and postoperative complications, reoperations, secondary surgical procedures and possible risk factors. Of 475 patients who underwent the procedure, 405 did not have additional full-thickness skin grafts while 70 did have grafts. Median follow up was 7.8 years. The most frequently observed intraoperative complication was rectal injury (2.3 percent). Short-term postoperative bleeding that required transfusion (4.8 percent), reoperation (1.5 percent) or both (0.4 percent) occurred in some cases. Major complications were three (0.6 percent) rectoneovaginal fistulas, which were successfully treated. Revision vaginoplasty was performed in 14 patients (2.9 percent). Co-morbid diabetes was associated with a higher risk of local infection, and use of psychotropic medication predisposed to postoperative urinary retention. Successful vaginal construction without the need for secondary functional reoperations was achieved in the majority of patients.

Bouman et al. (2016) prospectively assessed surgical outcomes of primary total laparoscopic sigmoid vaginoplasty in 42 transgender women with penoscrotal hypoplasia. Mean follow-up time was 3.2 ±2.1 years. The mean operative duration was 210 ±44 minutes. There were no conversions to laparotomy. One rectal perforation was recognized during surgery and immediately oversewn without long-term consequences. The mean length of hospitalization was 5.7 ±1.1 days. One patient died as a result of an extended-spectrum beta-lactamase-positive necrotizing fasciitis leading to septic shock, with multiorgan failure. Direct postoperative complications that needed laparoscopic reoperation occurred in three cases (7.1 percent). In seven cases (17.1 percent), long-term complications needed a secondary correction. After 1 year, all patients had a functional neovagina with a mean depth of 16.3 ±1.5 cm.

Despite the significant increase in genital gender affirming surgery (GAS) within the past 50 years, there is limited data regarding hair removal practices in preparation for genital GAS. Genital GAS involves reconstruction of the genitals to match a patient's identified sex. The use of hair-bearing flaps in this procedure may result in postoperative intra-vaginal and intra-urethral hair growth and associated complications, including lower satisfaction with genital GAS. In 2016, Zhang et al. conducted a literature review, recommendations from experience, and a practical laser hair removal (LHR) approach to hair removal prior to genital GAS.

Horbach et al. (2015) conducted a systematic review of vaginoplasty techniques in MtF individuals with gender dysphoria. Twenty-six studies were included (mostly retrospective case series of low to intermediate quality). Outcome of the penile skin inversion technique was reported in 1,461 patients and bowel vaginoplasty in 102 patients. Neovaginal stenosis was the most frequent complication in both techniques. Sexual function and patient satisfaction were overall acceptable, but many different outcome measures were used. Quality of life was only reported in one study. Comparison between techniques was difficult due to the lack of standardization. The authors concluded that the penile skin inversion technique is the most researched surgical procedure. Outcome of bowel vaginoplasty has been reported less frequently but does not seem to be inferior. The available literature is heterogeneous in patient groups, surgical procedure, outcome measurement tools, and follow up. There is a need for prospective studies with standardized surgical procedures, larger patient groups and longer follow-up periods. Uniformity in outcome measurement tools such as validated questionnaires and scores for sexual function and quality of life is mandatory for correct interpretation and comparability of data.

Bouman et al. (2014) conducted a systematic review of surgical techniques and clinical outcomes of intestinal vaginoplasty. Twenty-one studies were included (n = 894). All studies had a retrospective design and were of low quality. Prevalence and severity of procedure-related complications were low. The main postoperative complication was introital stenosis, necessitating surgical correction in 4.1% of sigmoid-derived and 1.2% of ileum-derived vaginoplasties. Neither diversion colitis nor cancer was reported. Sexual satisfaction rate was high, but standardized questionnaires were rarely used. Quality of life was not reported. The authors concluded that prospective studies, using standardized measures and questionnaires, are warranted to assess functional outcomes and quality of life.


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Djordjevic et al. (2013) evaluated 207 patients who underwent single-stage metoidioplasty, comparing two different surgical techniques of urethral lengthening. The procedure included lengthening and straightening of the clitoris, urethral reconstruction and scrotoplasty with implantation of testicular prostheses. Buccal mucosa graft was used in all cases for dorsal urethral plate formation and joined with one of the two different flaps: longitudinal dorsal clitoral skin flap (n = 49) (group 1) and labia minora flap (n = 158) (group 2). The median follow up was 39 months. The total length of reconstructed urethra ranged from 9.1 to 12.3 cm in group 1 and from 9.4 to 14.2 cm in group 2. Voiding while standing was significantly better in group 2 (93%) than in group 1 (87.82%). Urethral fistula occurred in 16 patients in both groups. Overall satisfaction was noted in 193 patients. The authors concluded that combined buccal mucosa graft and labia minora flap was the method of choice for urethroplasty in metoidioplasty, minimizing postoperative complications.

In a non-randomized study, Dhejne et al. (2011) evaluated mortality, morbidity and criminal rates after gender reassignment surgery in 324 individuals (MtF n = 191; FtM n = 133). Random population controls (10:1) were matched by birth year and birth sex or reassigned final sex. The authors reported substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts and psychiatric hospitalizations in sex-reassigned individuals (both MtF/FtM) compared to a healthy control population. FtMs had a higher risk for criminal convictions.

Murad et al. (2010) conducted a systematic review to evaluate the effects of hormone therapy on patients undergoing gender reassignment surgery. The authors identified 28 eligible studies, all of which were observational and most lacked controls. These studies enrolled 1833 participants with gender dysphoria (1093 MtF; 801 FtM). After gender reassignment surgery, individuals reported improvement in gender dysphoria (80%), psychological symptoms (78%), sexual function (72%) and quality of life (80%). The authors concluded that very low-quality evidence suggests that gender reassignment, that includes hormonal interventions, is likely to improve gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.

Sutcliffe et al. (2009) systematically reviewed five individual procedures for MtF gender reassignment surgery: clitoroplasty, labiaplasty, orchiectomy, penectomy and vaginoplasty. Further evaluations were made of eight surgical procedures for FtM gender reassignment surgery: hysterectomy, mastectomy, metoidioplasty, phalloplasty, salpingo-oophorectomy, scrotoplasty/placement of testicular prostheses, urethroplasty and vaginectomy. Eighty-two published studies (38 MtF; 44 FtM) were included in the review. For MtF procedures, the authors found no evidence that met the inclusion criteria concerning labiaplasty, penectomy or orchiectomy. A large amount of evidence was available concerning vaginoplasty and clitoroplasty procedures. The authors reported that the evidence concerning gender reassignment surgery in both MtF and FtM individuals with gender dysphoria has several limitations including lack of controlled studies, lack of prospective data, high loss to follow-up and lack of validated assessment measures. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence.

## World Professional Association for Transgender Health (WPATH)

WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, is an advocacy group devoted to transgender health. WPATH guidelines (2012) present eligibility and readiness criteria for transition-related treatment, as well as competencies of health care providers. WPATH is currently reviewing their Standards of Care with an anticipated release date for their update of 2022.

WPATH describes the transition from one gender to another in the following three stages:

- Living in the gender role consistent with gender identity
- The use of hormone therapy after living in the new gender role for a least three months
- Gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months

## Clinical Practice Guidelines

### *American Academy of Pediatrics (AAP)*

In a 2018 policy statement entitled Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, the AAP states the following regarding surgery: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults, they are occasionally pursued during adolescence on a case-by case basis, considering the necessity and benefit to the


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adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family (Rafferty et al, 2018).

### *American College of Obstetrics and Gynecology (ACOG)*

An ACOG committee opinion (2021) provides guidance on health care for transgender and gender diverse individuals. The document does not make specific recommendations regarding surgery but does provide an overview of surgical procedures and education for clinicians who care for transgender patients before and after surgery.

### *Endocrine Society*

Endocrine Society practice guidelines (Hembree et al., 2017) addressing endocrine treatment of gender-dysphoric/ gender-incongruent persons makes the following recommendations regarding surgery for sex reassignment and gender confirmation:

- Suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country (Recommendation based on low quality evidence).
- A patient pursues genital gender-affirming surgery only after the mental health practitioner (MHP) and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being (Strong recommendation based on low quality evidence).
- Surgery is recommended only after completion of at least one year of consistent and compliant hormone treatment unless hormone therapy is not desired or medically contraindicated (Ungraded Good Practice Statement).
- The physician responsible for endocrine treatment medically clears individual for surgery and collaborates with the surgeon regarding hormone use during and after surgery (Ungraded Good Practice Statement).
- Recommend that clinicians refer hormone treated transgender individuals for genital surgery when (strong recommendation based on very low-quality evidence):
  - The individual has had a satisfactory social role change.
  - The individual is satisfied about the hormonal effects.
  - The individual desires definitive surgical changes.
- Suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement (recommendation based on very low-quality evidence).

### *University of California, San Francisco (UCSF) Center of Excellence for Transgender Health*

The UCSF Center of Excellence evidence-based guidelines for the primary and gender-affirming care of transgender and gender nonbinary people address various surgical procedures, including risks, complications, approaches and perioperative and postoperative care (Deutsch, 2016).

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Gender transformation surgeries are procedures, and therefore, not subject to FDA regulation. However, medical devices, drugs, biologics, or tests used as a part of these procedures may be subject to FDA regulation. Refer to the following website to search by product name. Refer to: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm.
(Accessed July 12, 2022)

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# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 06/01/2023 | **Related Policies**<br>• Added reference link to the Medical Policy titled *Habilitation and Rehabilitation Therapy (Occupational, Physical and Speech) (for Pennsylvania Only)*<br>• Removed reference link to the Medical Policy titled *Speech Language Pathology Services (for Pennsylvania Only)* |
| 03/01/2023 | **Coverage Rationale**<br>• Revised coverage criteria for **genital surgery for Gender Dysphoria**; replaced criterion requiring an individual must:<br>  ○ "Complete at least 12 months of successful continuous full-time real-life *experience* in the *desired* gender" with "complete at least 12 months of successful continuous full-time real-life *involvement* in the *experienced* gender"<br>  ○ "Complete 12 months of continuous *cross-sex* hormone therapy appropriate for the *desired* gender (unless medically contraindicated)" with "complete 12 months of continuous hormone therapy appropriate for the *experienced* gender (unless medically contraindicated)"<br>**Supporting Information**<br>• Updated *Benefit Considerations*, *Clinical Evidence*, and *References* sections to reflect the most current information at the time of review<br>• Archived previous policy version CS145PA.K |


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# Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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