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Reviewed: 06/28/16

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Subject: Gender Reassignment Surgery

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

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DESCRIPTION:

NOTE: Coverage for gender reassignment is subject to the member's benefit terms, limitations and maximums. Refer to specific contract language regarding gender reassignment.

Gender reassignment surgery, also known as [transsexual](#) surgery, is the collection of several procedures designed to change the anatomy of individuals with gender identity disorders (GID).

Gender reassignment surgery, along with endocrine (hormone) therapy and real-life experience, is an accepted treatment of individuals diagnosed with transsexualism or profound GID.

The general goal of surgery, endocrine therapy, and psychotherapy for individuals diagnosed with GID is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment. Prior to gender reassignment surgery, medical and psychological evaluations, medical therapies, and behavioral trials are recommended to confirm that surgery is an appropriate choice for the individual.

Gender reassignment surgery is intended to be a permanent change to an individual's sexual identity and is not reversible. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrinologic, and urological examination, and a clinical psychiatric/psychological examination. An individual's self-assessment and request for sex reassignment cannot be viewed as reliable indicators of GID.

POSITION STATEMENT:

NOTE: Coverage for gender reassignment is subject to the member's benefit terms, limitations and maximums. Refer to specific contract language regarding gender reassignment.

For purposes of this guideline, gender reassignment surgery may include any of the following procedures:

- Male-to-Female Procedures
 - Clitoroplasty
 - Labiaplasty
 - Orchiectomy
 - Penectomy
 - Vaginoplasty
- Female-to-Male Procedures
 - Hysterectomy
 - Metoidioplasty
 - Phalloplasty
 - Salpingo-oophorectomy
 - Scrotoplasty
 - Testicular prostheses placement
 - Urethroplasty
 - Vaginectomy
 - Breast reduction.

Gender reassignment surgery **meets the definition of medically necessary** when **ALL** of the following criteria are met:

1. The individual has been diagnosed with the gender identity disorder (GID), including **ALL** of the following:
 - a. 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**
 - b. The transsexual identity has been present persistently for 2 years or more; **AND**
 - c. The disorder is not a symptom of another mental disorder or a chromosomal abnormality; **AND**
 - d. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; **AND**
2. For individuals without any medical contraindication, the individual has undergone at least 12 months of continuous hormonal therapy as recommended by a mental health professional and provided under the supervision of a physician; **AND**
3. The individual has completed 12 months or more of successful continuous full time real-life experience in their new gender, without returning to their original gender, including **ONE OR MORE** of the following:

- a. Maintain part- or full-time employment; **OR**
 - b. Function as a student in an academic setting; **OR**
 - c. Function in a community-based volunteer activity; **AND**
4. The individual has provided documentation to the treating therapist that persons other than the treating therapist know that the individual functions in the desired gender role; **AND**
 5. Regular participation in psychotherapy throughout the real-life experience as recommended by a treating medical or behavioral health practitioner; **AND**
 6. Demonstrates knowledge and understanding of the required length of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches; **AND**
 7. Demonstrates progress in consolidating one's gender identity, including demonstrating progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (i.e., this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidal tendencies); **AND**
 8. A letter from the individual's physician or mental health provider, who has treated the individual for a 18 months or more, documenting **ALL** of the following:
 - a. The individual's general identifying characteristics; **AND**
 - b. The initial and evolving gender, sexual, and other psychiatric diagnoses; **AND**
 - c. The duration of their professional relationship including the type of psychotherapy or evaluation that the individual underwent; **AND**
 - d. The eligibility criteria that have been met and the physician or mental health professional's rationale for surgery; **AND**
 - e. The degree to which the individual has followed the eligibility criteria to date and the likelihood of future compliance; **AND**
 - f. Whether the author of the report is part of a gender identity disorder treatment team; **AND**
 9. A letter from a second physician or mental health provider familiar with the individual's treatment and the psychological aspects of GID, corroborating the information provided in the first letter (see #10 above); **AND**
 10. When one of the letters indicated above is not from the treating surgeon, a letter from the surgeon confirming that that they have personally communicated with the treating mental health provider or physician, as well as the individual, and confirming that the individual meets the above criteria, understands the ramifications and possible complications of surgery, and that the surgeon feels that the individual is likely to benefit from surgery.

NOTE: At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D.) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.

Gender reassignment surgery **does not meet the definition of medical necessity** when one or more of the criteria listed above have not been met.

The following surgeries are considered **cosmetic** and **do not meet the definition of medical necessity** when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery (this is not an all-inclusive list):

- Blepharoplasty

- Breast augmentation
- Face lift
- Facial bone reconstruction
- Hair removal/hairplasty
- Liposuction
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery

BILLING/CODING INFORMATION:

CPT Coding:

55970	Intersex surgery; male to female
55980	Intersex surgery; female to male

Additionally, the following combinations of individual procedures may be billed separately:

19325	Mammoplasty, augmentation; with prosthetic implant
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy
55180	Scrotoplasty; complicated
56625	Vulvectomy, simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall;

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
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);
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; 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)

REIMBURSEMENT INFORMATION:

Refer to section entitled [POSITION STATEMENT](#).

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products:

No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline reviewed date.

DEFINITIONS:

Transsexual: individuals with an overwhelming desire to change anatomic sex because of their fixed conviction that they are members of the opposite sex.

RELATED GUIDELINES:

None

OTHER:

Other indexing terms relating to gender reassignment:

Gender change

Gender identity disorder

Intersex surgery

Sex change

Sex reassignment surgery

Sex reversal

Sex transformation surgery

Transgender surgery

Transsexual reassignment

Transsexual surgery

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy & Coverage Committee on 06/28/16.

GUIDELINE UPDATE INFORMATION:

11/15/11	New Medical Coverage Guideline.
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10/15/12	Annual review; position statement unchanged; references updated.
11/15/13	Annual review; position statement unchanged; Program Exceptions section updated; references updated.
11/15/14	Annual review; position statement unchanged; Program Exceptions section updated; references updated.
07/15/16	Revision; guideline title and position statements section updated.
10/01/16	Revision; coding section updated.
12/28/18	Revision; position statement updated.