02-55900-01

Original Effective Date: 11/15/11

Reviewed: 02/25/21

Revised: 02/26/21

Subject: Gender Affirmation 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.

DESCRIPTION:

Gender affirmation surgery, also known as sexual reassignment surgery, gender reassignment surgery, or gender confirming surgery, is the collection of multiple medical and surgical procedures to treat gender dysphoria.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines gender dysphoria in adults as:

1. 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:
   - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).
   - 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 (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   - A strong desire for the primary and /or secondary sex characteristics of the other gender.
   - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   - 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).
2. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

POSITION STATEMENT:

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

Female to Male surgery

Hysterectomy and ovariectomy for female to male members **meets the definition of medical necessity** when **ALL** of the following are met:

A. Member is 18 years or older
B. Member has the capacity to make a fully informed decision and to consent for treatment
C. Documentation shows persistent and well documented gender dysphoria
D. No medical contraindications to surgery
E. Any mental health concerns are well controlled
F. Documentation of 12 continuous months of hormone therapy (unless the member has a medical contraindication or is otherwise unable to take hormones); AND
G. Referral letters from two independent licensed mental health professionals unless referred through a multidisciplinary team.

Metoidioplasty or phalloplasty for female to male members **meets the definition of medical necessity** when **ALL** of the following are met:

A. Member is 18 years or older
B. Member has the capacity to make a fully informed decision and to consent for treatment
C. Documentation shows persistent and well documented gender dysphoria
D. No medical contraindications to surgery
E. Any mental health concerns are well controlled
F. Documentation of 12 continuous months of hormone therapy (unless the member has a medical contraindication or is otherwise unable to take hormones); AND
G. Referral letters from two independent licensed mental health professionals unless referred through a multidisciplinary team.

Mastectomy and creation of a male chest for female to male members **meets the definition of medical necessity** when **ALL** of the following are met:

A. Member is 18 years or older
B. Member has the capacity to make a fully informed decision and to consent for treatment
C. Documentation shows persistent and well documented gender dysphoria
D. No medical contraindications to surgery
E. Any mental health concerns are well controlled; AND
F. One referral letter from a licensed mental health professional.

(Note: Hormone therapy is not a pre-requisite.)

Male to Female Surgery

Orchiectomy, penectomy for male to female members **meets the definition of medical necessity** when **ALL** of the following are met:

A. Member is 18 years or older
B. Member has the capacity to make a fully informed decision and to consent for treatment
C. Documentation shows persistent and well documented gender dysphoria
D. No medical contraindications to surgery
E. Any mental health concerns are well controlled
F. Documentation of 12 continuous months of hormone therapy (unless the member has a medical contraindication or is otherwise unable to take hormones); AND
G. Referral letters from two independent licensed mental health professionals unless referred through a multidisciplinary team.

Vaginoplasty, clitoroplasty, vulvoplasty for male to female members **meets the definition of medical necessity** when **ALL** of the following are met:

A. Member is 18 years or older
B. Member has the capacity to make a fully informed decision and to consent for treatment
C. Documentation shows persistent and well documented gender dysphoria
D. No medical contraindications to surgery
E. Any mental health concerns are well controlled
F. Documentation of 12 continuous months of hormone therapy (unless the member has a medical contraindication or is otherwise unable to take hormones); AND
G. Referral letters from two independent licensed mental health professionals unless referred through a multidisciplinary team.

Breast augmentation (implants/lipofilling) for male to female members **meets the definition of medical necessity** when **ALL** of the following are met:

A. Member is 18 years or older
B. Member has the capacity to make a fully informed decision and to consent for treatment
C. Documentation shows persistent and well documented gender dysphoria
D. No medical contraindications to surgery
E. Any mental health concerns are well controlled
F. Documentation of 12 continuous months of hormone therapy (unless the member has a medical contraindication or is otherwise unable to take hormones); AND
G. One referral letter from a licensed mental health professional.

Other

Procedures primarily for feminization or masculinization are considered aesthetic (cosmetic) and excluded from coverage on most contracts. Procedures considered **cosmetic** include but are not limited to the following:

- Blepharoplasty

- Face lift
- Facial bone reconstruction
- Hair removal/hairplasty
- Liposuction
- Nose implants
- 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:

19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant
53430	Urethroplasty, reconstruction of female urethra
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)

ICD-10 Diagnosis Codes That Support Medical Necessity:

F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified

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:

The following National Coverage Determination (NCD) was reviewed on the last guideline reviewed date: National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9); located at cms.gov.

DEFINITIONS:

None applicable.

RELATED GUIDELINES:

Blepharoplasty/Brow Surgical Procedures, 02-65000-11
Infertility, 02-56000-24
Reconstructive Surgery/Cosmetic Surgery, 02-12000-01
Reduction Mammoplasty, 02-12000-11

OTHER:

Referral letters for surgery may include the following documentation:

1. The patient's general identifying characteristics;
2. Results of the patient's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the patient, 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; and
5. A statement about the fact that informed consent has been obtained from the patient.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy & Coverage Committee on 02/25/21.

GUIDELINE UPDATE INFORMATION:

11/15/11	New Medical Coverage Guideline.
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.
05/15/19	Review; Position maintained; description, position statements, and references updated.
08/28/20	Revision; coding section updated.
01/01/21	Annual CPT/HCPCS update. Codes 19318 and 19325 revised.
02/26/21	Review; Position statements, coding, and references updated.