Medical Policy Reference Manual
Medical Policy

7.01.123 Gender Affirmation Services /Gender Dysphoria

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Description

The Transgender Health Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People, published by World Professional Association for Transgender Health (WPATH), describe gender dysphoria as discomfort or distress that is caused 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).

Similarly, Knudson, DeCuypere & Blockting, 2010, defined gender dysphoria as discomfort or distress related to incongruence between a person's gender identity, sex assigned at birth, gender identity, and/or primary and secondary sex characteristics. In 2013, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5 [American Psychiatric Association, 2013]) adopted the term gender dysphoria as a diagnosis characterized by "a marked incongruence between" a person's gender assigned at birth and gender identity (American Psychiatric Association, 2013).

Treatment options for gender dysphoria include:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g., breast/chest, external and/or internal genitalia, facial features, body contouring); or
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression, addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

The number and type of treatment interventions applied and the order in which these take place may differ from person to person.

Policy

Gender reassignment services (surgical and non-surgical) are each subject to review to determine if the services are considered medically necessary, cosmetic, or reconstructive. Preauthorization is not required by all contracts, and in these circumstances the review will occur post service.

* NOTE: See Medical Policy 7.01.017 Cosmetic and Reconstructive Surgery with Attached Companion Table

Policy Guidelines

The following criteria are based on the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7, published by the World Professional Association for Transgender Health (WPATH).

Gender Reassignment Surgery

Gender reassignment surgery is considered medically necessary when ALL of the following criteria are met:

1. The individual is age 18 years or older; and

2. The individual has a confirmed diagnosis of gender dysphoria including all the following:
   - gender dysphoria resulting in clinically significant distress or impairment in social and occupational areas of functioning; and
   - the disorder or dysphoria is not a symptom of another mental disorder; and
   - the desire to live and be accepted as a member of the opposite sex, accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery or hormone treatment; and
   - transsexual identity has been persistently present for at least 2 years; and

3. For those without a medical contraindication to hormonal therapy, the individual has undergone a minimum of 12 continuous months of hormonal therapy that was recommended by a mental health professional and supervised by a physician over the entire 12-month period (1); and

(1) Hormone therapy is not a prerequisite for mastectomy and mammoplasty.

4. Documentation that the individual has completed a minimum of 12 months of successful continuous full-time, real-life experience in their desired gender, across a wide span of life experiences and events that may occur throughout the year (i.e., holidays, vacations, season-specific school and/or work experience, family events), where;
   - the documentation includes the start date of living in the desired gender role; and
   - verification via medical or mental health professional* communication with persons who have related to the individual in an identity-congruent gender role, or documentation of a legal name change; and
   - regular active participation in a recognized gender dysphoria treatment program; and

5. The individual has received the following referrals for surgery:

- One letter of referral from a licensed mental health professional, if the individual is seeking breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty)

- Two letters from qualified mental health professionals* who have independently assessed the individual if the individual is seeking genital surgery. If the first letter is from the individual's psychotherapist, the second letter must be from a licensed mental health professional who can confirm the diagnosis of gender dysphoria. The content of each letter should include:
  - the individual's general identifying characteristics; and
  - results of a psychosocial assessment, including any diagnoses; and
  - the duration of the professional relationship with the individual, including the type of evaluation and therapy or counseling to date; and
  - explanation that the criteria for surgery have been met, and a brief clinical rationale for supporting the individuals request for surgery; and
  - a statement that the individual is capable of providing informed consent; and
  - a statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

*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 any comorbid psychiatric conditions. A single letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the other specifications listed.

The gender reassignment surgeries that may be performed for transwomen (male to female) that meet the above 5 criteria include but are not limited to:
- Orchiectomy: removal of testicles

- Penectomy: removal of penis
- Vaginoplasty: creation of vagina
- Clitoroplasty: creation of clitoris
- Labiaplasty: creation of labia
- Prostatectomy: removal of prostate
- Urethroplasty: creation of urethra
- Mammoplasty: breast augmentation

The gender reassignment surgeries that may be performed for transmen (female to male) that meet the above 5 criteria include but are not limited to:
- Salpingo-oophorectomy: removal of fallopian tubes and ovaries
- Vaginectomy: removal of vagina
- Vulvectomy: removal of vulva
- Metoidioplasty: creation of micro-penis using the clitoris
- Phalloplasty: creation of penis, with or without urethra
- Hysterectomy: removal of uterus
- Urethroplasty: creation of urethra within penis
- Scrotoplasty: creation of scrotum
- Testicular prosthesis: implantation of artificial testes
- Mastectomy: removal of the breast

Other surgeries for assisting in body feminization or body masculinization are generally labeled cosmetic as they provide no significant improvement in physiologic function. However, these surgeries can be considered medically necessary depending on the unique clinical situation of a given patient's condition. These surgeries include but are not limited to:
- Rhinoplasty: reshaping of the nose
- Rhytidectomy: face lift
- Blepharoplasty: removal of redundant skin of the upper and/or lower eyelids and protruding periorbital fat
- Hair removal via electrolysis, laser, and waxing/Hair transplantation
- Facial bone reduction: facial feminization
- Chin augmentation reshaping or enhancing the size of the chin
- Lip reduction/enhancement: decreasing/enlarging lip size
- Liposuction/Lipoplasty: removal of fat and/or contour modeling
- Lipofilling
- Voice modification surgery/Cricothyroid approximation: voice modification that raises the vocal pitch by stimulating contractions of the cricothyroid muscle with sutures
- Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage
- Laryngoplasty: reshaping of laryngeal framework (voice modification surgery)
- Gluteal augmentation via implants and lipofilling
- Pectoral implants
- Breast Augmentation
- Genioplasty

Cancer Screenings

Professional organizations such as the American Cancer Society, American College of Obstetricians and Gynecologists and the U.S. Preventive Services Task Force provide recommended preventive and cancer screening guidelines to facilitate clinical decision-making by professional providers. Gender specific screenings may be medically necessary for transgender persons appropriate to their anatomy. Examples include:
- Cervical cancer screening may be medically necessary for transmen persons who have not undergone a hysterectomy.
- Breast cancer screening may be medically necessary for transmen persons who have not undergone a mastectomy.
- Prostate cancer screening may be medically necessary for transwomen persons who have retained their prostate.

Other Gender Reassignment Services

1. Hormone therapy for adults

Authorization of 12 months for hormone therapy is considered medically necessary for individuals over age 18 who are prescribed hormone therapy for the treatment of gender dysphoria when ALL of the following criteria are met:

- The member is undergoing gender reassignment, and
- The member will receive hormone suppression therapy concomitantly with feminizing/masculinization hormone therapy

For continuation of therapy, individuals must meet ALL of the initial authorization criteria.

2. Hormone therapy for individuals under the age of 18:

- For those without a medical contraindication to hormonal therapy, authorization of 12 months of hormone therapy is considered medically necessary for young adolescents with a diagnosis of gender dysphoria who are prescribed hormone therapy when ALL of the following criteria are met:
- Hormone therapy is prescribed for pubertal suppression for the treatment of gender dysphoria; and
- The individual has reached at least Tanner stage 2 of puberty.

Authorization of for continuation therapy must meet ALL initial authorization criteria.

Refer to CVS Caremark Specialty Guideline Management: Lupron Depot-PED and WPATH criteria Section VI.

Update 2017:

A search of the peer-reviewed literature was performed for the period of December 2015 through December 2017. Findings in the recent literature do not change the current conclusions regarding gender reassignment services. Therefore, the policy remains unchanged.

Update 2020:

A search of the peer-reviewed literature was performed from the period of January 2018 through February 2020. Findings in the recent literature do not change the conclusions regarding gender reassignment services. Therefore, the policy remain unchanged.

Benefit Applications

NOTE: Check the member's contract for benefits. Some procedures associated with gender reassignment surgery may be considered cosmetic in nature and not medically necessary.

When benefits are provided in the member's contract, benefits are provided for transgender services determined by CareFirst to be medically necessary.

Benefits are not provided for services determined by CareFirst to be not medically necessary, experimental / investigational or cosmetic.

NOTE: For FEP business check the member's contract for benefits.

Provider Guidelines

Before initiating a request for authorization of services, benefits must be verified. **If benefits are available in the member's contract, prior authorization may be required to determine appropriateness and medical necessity for treatment.**

Submit documentation for review to:

Preservice Review Department
CareFirst BlueCross BlueShield
1501 S. Clinton Street
8th Floor, Mail Stop CT-08-02
Baltimore, MD 21224
866-PREAUTH

Preservice Review Fax: 410-720-3060

Services for the treatment of gender dysphoria should be reported using the appropriate Category I CPT® code appended with HCPCS modifier KX (Requirements specified in the medical policy have been met).

Cross References to Related Policies and Procedures

Cosmetic and Reconstructive Surgery with Attached Companion Table Policy 7.01.017
Assisted Reproduction Technology (ART) Procedures: In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT) Policy 4.02.001

References

The following were among the resources reviewed and considered in developing this policy. By reviewing and considering the resources, CareFirst does not in any way endorse the contents thereof nor assume any liability or responsibility in connection therewith. The opinions and conclusions of the authors of these resources are their own, and may or may not be in agreement with those of CareFirst.

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This policy statement relates only to the services or supplies described herein. Coverage will vary from contract to contract and by line of business and should be verified before applying the terms of the policy.