

GENDER AFFIRMING SURGERY**Effective Date:** December 1, 2024**Review Dates:** 8/15, 8/16, 11/16, 8/17, 8/18, 8/19,
8/20, 5/21, 8/21, 8/22, 11/22, 5/23, 11/23, 11/24**Date Of Origin:** August 12, 2015**Status:** Current*Note: Policy was previously titled Gender Reassignment Surgery***Summary of Changes**

Deletion: I.B. – Removed note about reproductive services

I. POLICY/CRITERIA

Gender affirming surgery (GAS), including pre- and post-surgical hormone therapy, is considered medically necessary when **ALL** of the following criteria are met:

- 1) age 18 or older, **AND**
- 2) diagnosis of gender incongruence/dysphoria made by licensed practitioner with expertise in gender dysphoria, incongruence, and diversity, **AND**
- 3) capacity to make a fully informed decision and to consent for treatment, **AND**
- 4) acknowledge aftercare requirements and importance of pre- and post-operative aftercare requirements, **AND**
- 5) gender affirming surgical procedure is completed by surgeon with training and active practice in gender-affirming surgical procedures

If medically necessary criteria for coverage for gender affirming surgery are met, the following conditions of coverage apply:

- A. Gender affirming chest surgery “top surgery” (i.e., initial mastectomy, breast reduction) is considered medically necessary for members assigned female at birth when criteria I. 1-3 are met.

Note: Trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

- B. Gonadectomy (Hysterectomy and salpingo-oophorectomy assigned female at birth and orchiectomy in assigned male at birth) when **BOTH** of the following additional criteria are met:

1. Documentation of at least 6 months of continuous hormonal therapy for gender incongruence/ dysphoria.
2. Documentation of permanence resultant proposed GAS

- C. Genital Reconstructive surgery (i.e., including colpectomy vaginectomy, urethroplasty, metoidioplasty with initial phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in patients assigned female at birth; including colovaginoplasty penectomy, vaginoplasty, labiaplasty, and clitoroplasty repair of introitus, construction of vagina with graft, coloproctostomy in patients assigned male at birth) when **ALL** of the following criteria are met:
1. Documentation of at least 6 months of continuous hormonal therapy for gender incongruence/ dysphoria (May be simultaneous with real life experience), **AND**
 2. The individual has lived within the desired gender role for at least 12 continuous months, which includes a wide range of life experiences and events (e.g., family events, holidays, vacations, season-specific work or school experiences), including notification to partners, family, friends, and community members (e.g., at school, work, other settings) of their identified gender, **AND**
 3. The individual is an active participant in a recognized gender identity treatment program.
- D. A limited number of electrolysis or laser hair removal sessions may be considered medically necessary for skin graft preparation for genital surgery.
- E. The procedures listed below may be considered medically necessary only when performed as part of a component of a comprehensive facial feminization or facial masculinization service performed as an adjunct to gender affirming surgery (items A, B, or C, as above) following a diagnosis of gender dysphoria:

Feminization/Masculinization Procedures	CPT/HCPCS Code(s)
Adjacent tissue transfer or rearrangement (forehead, cheeks, chin, mouth)	14041
Blepharoplasty*	15820, 15821, 15822, 15823
Brow lift*	67900
Cheek/malar implants	17999
Chin/nose implants, chin recontouring	21210, 21270, 30400, 30410, 30420, 30430 30435, 30450
Collagen injections, limited to facial	11950, 11951, 11952, 11954
Face lift	15824, 15825, 15826, 15828, 15829

Forehead reduction and contouring	21137, 21139
Facial bone reduction (osteoplasty)	21209
Grafting of autologous soft tissue	15769
Jaw reduction, contouring, augmentation	21120, 21121, 21122, 21123, 21125, 21127, 21193
Laryngoplasty	31599
Reconstruction superior-lateral orbital rim and lower forehead	21172
Rhinoplasty*	21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450
Skin resurfacing (e.g., dermabrasion, chemical peels) limited to facial	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Thyroid reduction chondroplasty	31750
Electrolysis other than when performed prevaginoplasty as outlined above (i.e., face, neck) and limited to eight 30-minute timed units per day	17380
Suction assisted lipoplasty, lipofilling, and/or liposuction (i.e., head, neck)	15839, 15876

* An isolated blepharoplasty, brow lift, or rhinoplasty, not completed as a component of a comprehensive feminization or masculinization service, is subject to the terms, conditions, limitations, and medical necessity criteria specified in Priority Health Medical Policy 91535 – *Cosmetic and Reconstructive Surgery Procedures*.

- F. Procedures associated with gender affirmation surgery that are performed solely for the purpose of improving or altering appearance or self-esteem related to one's appearance, are considered cosmetic in nature and not medically necessary.

The following are considered cosmetic in nature and not medically necessary when performed as a component of a gender affirmation, even when there is a benefit for gender affirming surgery (this list may not be all-inclusive):

- Breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast
- Forehead augmentation
- Gluteal and hip augmentation
- Hair reconstruction (transplantation or removal, except as noted in I D above)
- Liposuction and lipofilling, non-facial
- Mastopexy

- Nipple/areola reconstruction
- Pectoral implants
- Skin resurfacing, non-facial (e.g., dermabrasion, chemical peel)
- Voice modification surgery

Note on gender specific services for the transgender community:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male trans-identified persons who have not undergone a mastectomy.
2. Prostate cancer screening may be medically necessary for male to female trans-identified persons who have retained their prostate.

Note: Reversal of gender affirming surgery is not a covered benefit.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the [Priority Health Provider Manual](#).

III. APPLICATION TO PRODUCTS

Gender affirming surgery, including pre- and post-hormone therapy, is a covered service to the extent as required, limited, and/or enforceable by applicable state and/or federal law, and the above criteria are met, including being provided by a facility approved in advance by Priority Health. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

Any procedure or treatment that is not medically/clinically necessary or is considered cosmetic, experimental or investigational, is not covered.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*

- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

IV. BACKGROUND

Gender-affirmation surgery (GAS) refers to a constellation of procedures designed to align a person's body with their gender identity. Recognizing the diverse and heterogeneous community of individuals who identify as transgender and gender diverse (TGD), gender-affirming surgical interventions may be categorized along a spectrum of procedures for individuals assigned male at birth (AMAB) and assigned female at birth (AFAB).

Hormone replacement therapy (HRT) plays an important role in the gender associated medical and surgical treatment (GAMST) process. Patients assigned male at birth are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Patients assigned female at birth are treated with testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes HRT may be effective in reducing the adverse psychologic impact of gender incongruence/dysphoria.

Gender incongruence /dysphoria undergoes what is referred to as a "real life experience", prior to irreversible genital surgery, in which he/she adopts the new or evolving gender role and lives in that role as part of the transition pathway. This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During this time, a person would be expected to maintain their

baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Gender affirmation surgery is intended to be a permanent change, establishing congruency between an individual's gender identity and physical appearance and is not easily 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, endocrine, and urological examination, and a clinical psychiatric/psychological examination.

Regret after GAS can be temporarily or permanent and may be classified as (Narayan et al., 2021) social regret (caused by difficulties in familial, religious, social, or professional life), medical regret (due to long-term medical complications, disappointment in surgical results of inadequate preoperative decision-making), and true gender-related regret (mostly based on patient experienced misdiagnosis, insufficient exploration of gender identity, or both).

Surgeons offering GAS may have a variety of surgical specialty training and backgrounds. The most common surgical specialties include plastic surgery, urology, gynecology, otolaryngology and oro-maxillofacial surgery (Jazayeri et al., 2021). Surgeons offering care for TGD people have received documented training in gender-affirming procedures and principles of gender-affirming care (Schechter et al., 2017; Schechter & Cohen 2019).

V. CODING INFORMATION

ICD-10 Codes that must be reported on claims and preauthorization requests relative to gender reassignment procedures:

F64.0	Transsexualism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

CPT/HCPCS Codes that may apply:

List should not be considered complete nor a guarantee of coverage:

55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
17380	Electrolysis epilation, each 30 minutes
19318	Breast reduction
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage

- 53425 Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
- 53430 Urethroplasty, reconstruction of female urethra
- 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
- 55175 Scrotoplasty; simple
- 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
- 57335 Vaginoplasty for intersex state
- 57426 Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
- 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
- 58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
- 58275 Vaginal hysterectomy, with total or partial vaginectomy
- 58552 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; 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)
- 58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

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