BENEFIT COVERAGE POLICY

Title: BCP-24 Gender Reassignment Surgery

Effective Date: 01/01/2019

Physicians Health Plan
PHP Insurance Company
PHP Service Company

Important Information - Please Read Before Using This Policy

The following coverage policy applies to health benefit plans administered by PHP and may not be covered by all PHP plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Coverage determinations for individual requests require consideration of:

- The terms of the applicable benefit document in effect on the date of service.
- Any applicable laws and regulations.
- Any relevant collateral source materials including coverage policies.
- The specific facts of the particular situation.

Contact PHP Customer Service to discuss plan benefits more specifically.

1.0 Policy:

Health Plan covers gender reassignment surgery as medically necessary when the individual is age 18 years or older, and has a confirmed diagnosis of gender dysphoria. All procedures related to gender reassignment surgery require prior approval for coverage.

For all non-network covered services to be paid at the network benefit level except for emergency/urgent services, prior approval is required.

Refer to member's benefit coverage document for specific benefit description, guidelines, coverage, and exclusions.

Unlisted codes are subject to review.

2.0 Background:

Gender dysphoria refers to a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort or distress caused by a discrepancy between an individual's gender identity and the gender assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). A diagnosis of gender dysphoria requires a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender reassignment surgery is not a single procedure, but part of a complex process involving multiple medical, psychiatric and surgical specialists working together with the individual to achieve successful behavioral and medical outcomes.

For male to female gender reassignment, surgical procedures may include genital reconstruction (vaginoplasty, penectomy, orchiectomy, clitoroplasty) and cosmetic surgery (breast implants, facial reshaping, rhinoplasty, abdominoplasty, thyroid chondroplasty (laryngeal shaving), voice modification surgery (vocal cord shortening), and hair transplants).

For female to male gender reassignment, surgical procedures may include mastectomy, genital reconstruction (phalloplasty, genitoplasty, hysterectomy, and bilateral oophorectomy), and cosmetic procedures to enhance male features such as pectoral implants and chest wall re-contouring.

Mental health professionals play a strong role in working with individuals with gender dysphoria as they need to diagnose the gender disorder and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, and provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. Once the individual is evaluated, the mental health professional provides documentation and formal recommendations to medical and surgical specialists.

Gender reassignment 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. A patient's self-assessment and desire for sex reassignment cannot be viewed as reliable indicators of gender dysphoria.

3.0 Clinical Determination Guidelines:

A. Male-to-female gender reassignment considered when C. 1-8 below are met:
   1. Orchiectomy
   2. Vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy)

B. Female-to-male gender reassignment:
   1. Breast surgery (i.e., initial mastectomy, breast reduction)
      a. Only one letter of support from a qualified mental health professional is required
      b. A trial of hormone therapy is not required to qualify for a mastectomy
   2. Hysterectomy and salpingo-oophorectomy – when C. 1-8 below are met
   3. Vaginectomy (including colpectomy, metoidioplasty, phalloplasty, urethroplasty, urethromeatoplasty) – when C. 1-8.a. below are met

C. Gender reassignment surgery, including pre- and post- surgical hormone therapy is covered when ALL the following are met:
   1. Individual is age 18 years or older, AND
   2. Has the capacity to make a fully informed decision and to consent for treatment, AND Member has been diagnosed with persistent, well documented gender dysphoria, which includes 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 gender dysphoria has been present persistently for at least two years; AND
      c. The condition is not a symptom of another mental disorder or a chromosomal abnormality; AND
      d. The condition causes clinically significant distress or impairment in social, occupation, or other important areas of functioning; AND

3. If significant medical or mental health concerns are present, must be reasonably well controlled, AND

4. Is an active participant in a recognized gender identity treatment program; AND

5. The patient has undergone a minimum of 12 months of continuous hormonal therapy❖ (unless contraindicated) when recommended by a mental health professional and provided under the supervision of a physician; AND

6. The patient has completed a minimum of 12 months of successful continuous, full time real-life experience in their new gender, with no 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

7. Recommendation for gender reassignment surgery by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery.
   a. One must be from a psychiatrist or psychologist with whom the patient has an established and ongoing professional relationship, (defined as the member having had at least 4 visits in a six- month time frame with the psychiatrist or psychologist)
   b. Second recommendation should be from a qualified mental health professional who only performed an evaluation of the individual
   c. Two separate letters are required, or one letter signed by both professionals. (for example, if both are practicing within the same clinic)

❖NOTE: for individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures, a total of 12 months of continuous hormonal sex reassignment therapy is required. An additional 12 months of hormone therapy is not required for vaginectomy or vaginoplasty procedures.

D. Any surgeon who performs gender reassignment surgery must be any of the following board certified or board qualified:
   1. Urologist
   2. Gynecologist
   3. Plastic surgeon
   4. Cosmetic surgeon
   5. General surgeon

E. Procedures not covered when performed prior to gender reassignment surgery:
   1. Preservation of fertility – procedures aimed at preservation of fertility (e.g., procurement, cryopreservation, and storage of sperm, oocytes and/or embryos) performed prior to gender reassignment surgery are considered not medically necessary.

F. Cosmetic procedures performed as part of gender reassignment surgery. These procedures are aimed at primarily improving a person’s appearance, are performed to assist with improving culturally appropriate male or female appearance characteristics and therefore are considered cosmetic and not medically necessary:
   1. Abdominoplasty
   2. Blepharoplasty, brow reduction, brow lift

3. Breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast
4. Calf implants
5. Chin augmentation (reshaping or enhancing the size of the chin)
6. Chin/nose/cheek/malar implants
7. Collagen injections
8. Electrolysis
9. Face/forehead lift
10. Gamete preservation in anticipation of future infertility
11. Gluteal and hip augmentation
12. Hair removal/hair transplantation
13. Insertion of penile prosthesis (non-inflatable/inflatable)
14. Insertion of testicular expanders
15. Jaw reduction or augmentation/facial bone reduction
16. Laryngoplasty
17. Lip reduction/enhancement
18. Liposuction/lipofilling
19. Mastopexy
20. Nipple/areola reconstruction
21. Pectoral implants
22. Penile prosthesis
23. Removal of redundant skin
24. Replacement of tissue expander with permanent prosthesis testicular insertion
25. Rhinoplasty
26. Scrotoplasty
27. Skin resurfacing (e.g., dermabrasion, chemical peels)
28. Testicular prosthesis
29. Trachea (Adam's apple) shave/reduction thyroid chondroplasty
30. Voice modification surgery
31. Voice therapy/voice lessons

4.0 Coding:

Prior Approval Legend: Y = All lines of business; N = None required; 1 = HMO/POS; 2 = PPO; 3 = ASO group L0000264; 4 = ASO group L0001269 Non-Union; 5 = ASO group L0001631; 6 = ASO group L0002011; 7 = ASO group L0001269 Union.

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
55970	Intersex surgery; male to female	Y	Benefits and Coverage; Gender Reassignment

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
			Treatment
	Includes only the follow procedures:	Y	
54125	Amputation of penis; complete	Y	Benefits and Coverage; Gender Reassignment Treatment
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	Y	Benefits and Coverage; Gender Reassignment Treatment
54690	Laparoscopy, surgical; orchiectomy	Y	Benefits and Coverage; Gender Reassignment Treatment
56800	Plastic repair of introitus	Y	Benefits and Coverage; Gender Reassignment Treatment
56805	Clitoroplasty for intersex state	Y	Benefits and Coverage; Gender Reassignment Treatment
57291	Construction of artificial vagina; without graft	Y	Benefits and Coverage; Gender Reassignment Treatment
57292	Construction of artificial vagina; with graft	Y	Benefits and Coverage; Gender Reassignment Treatment
57335	Vaginoplasty for intersex state	Y	Benefits and Coverage; Gender Reassignment Treatment
55980	Intersex surgery; female to male	Y	Benefits and Coverage; Gender Reassignment Treatment
	Includes only the follow procedures:	Y	
19303	Mastectomy, simple, complete	Y	Benefits and Coverage; Gender Reassignment Treatment
19304	Mastectomy, subcutaneous	Y	Benefits and Coverage; Gender Reassignment Treatment
53430	Urethroplasty, reconstruction of female urethra	Y	Benefits and Coverage; Gender Reassignment Treatment
56625	Vulvectomy simple; complete	Y	Benefits and Coverage; Gender Reassignment Treatment

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
57110	Vaginectomy, complete removal of vaginal wall	Y	Benefits and Coverage; Gender Reassignment Treatment
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	Y	Benefits and Coverage; Gender Reassignment Treatment
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	Y	Benefits and Coverage; Gender Reassignment Treatment
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Y	Benefits and Coverage; Gender Reassignment Treatment
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Y	Benefits and Coverage; Gender Reassignment Treatment
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Y	Benefits and Coverage; Gender Reassignment Treatment
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Y	Benefits and Coverage; Gender Reassignment Treatment
58573	Laparoscopy, surgical, with total hysterectomy, fur uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Y	Benefits and Coverage; Gender Reassignment Treatment
58661	Laparoscopy, surgical; with removal of adnexal structure (partial or total oophorectomy and/or salpingectomy)	Y	Benefits and Coverage; Gender Reassignment Treatment
58999◆	Unlisted procedure, female genital system (non-obstetrical)	Y	Benefits and Coverage; Gender Reassignment Treatment

◆ Covered when medically necessary to report metoidioplasty with phalloplasty

NON-COVERED CODES: Generally Excluded/Not Medically Necessary		
Code	**Description**	**Benefit Plan Reference/ Reason**
89258	Cryopreservation; embryo(s)	Defined Terms; Covered Health Services, Medically Necessary
89259	Cryopreservation; sperm	Defined Terms; Covered Health Services, Medically Necessary
89337	Cryopreservation, mature oocyte(s)	Defined Terms; Covered Health Services, Medically

NON-COVERED CODES: Generally Excluded/Not Medically Necessary		
Code	**Description**	**Benefit Plan Reference/ Reason**
		Necessary
89342	Storage (per year); embryo(s)	Defined Terms; Covered Health Services, Medically Necessary
89343	Storage (per year); sperm/semen	Defined Terms; Covered Health Services, Medically Necessary
89346	Storage (per year); oocyte(s)	Defined Terms; Covered Health Services, Medically Necessary
0357T	Cryopreservation; immature oocyte(s)	Defined Terms; Covered Health Services, Medically Necessary
S4027	Storage of previously frozen embryos	Defined Terms; Covered Health Services, Medically Necessary
S4030	Sperm procurement and cryopreservation services; initial visit	Defined Terms; Covered Health Services, Medically Necessary
S4031	Sperm procurement and cryopreservation services; subsequent visit	Defined Terms; Covered Health Services, Medically Necessary
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Defined Terms; Covered Health Services, Medically Necessary

NON-COVERED CODES: Experimental/Investigational/Unproven		
Code	**Description**	**Benefit Plan Reference/ Reason**
89335	Cryopreservation, reproductive tissue, testicular	Exclusion for Experimental, Investigational or Unproven Services
89344	Storage (per year); reproductive tissue, testicular/ovarian	Exclusion for Experimental, Investigational or Unproven Services
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	Exclusion for Experimental, Investigational or Unproven Services
0058T	Cryopreservation; reproductive tissue, ovarian	Exclusion for Experimental, Investigational or Unproven Services

NON-COVERED CODES: Cosmetic when performed as a component of gender reassignment surgery, even when coverage for gender reassignment surgery is approved		
Code	**Description**	**Benefit Plan Reference/ Reason**
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less	Specific exclusion for cosmetic procedures
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc	Specific exclusion for cosmetic procedures
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc	Specific exclusion for cosmetic procedures
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc	Specific exclusion for cosmetic procedures
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	Specific exclusion for cosmetic procedures
11970	Replacement of tissue expander with permanent prosthesis	Specific exclusion for cosmetic procedures
11971	Removal of tissue expander(s) without insertion of prosthesis	Specific exclusion for cosmetic procedures
15775	Punch graft for hair transplant; 1 to 15 punch grafts	Specific exclusion for cosmetic procedures
15776	Punch graft for hair transplant; more than 15 punch grafts	Specific exclusion for cosmetic procedures
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)	Specific exclusion for cosmetic procedures
15781	Dermabrasion; segmental, face	Specific exclusion for cosmetic procedures
15782	Dermabrasion; regional, other than face	Specific exclusion for cosmetic procedures
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)	Specific exclusion for cosmetic procedures
15786	Abrasion; single lesion (e.g., keratosis, scar)	Specific exclusion for cosmetic procedures
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	Specific exclusion for cosmetic procedures
15788	Chemical peel, facial; epidermal	Specific exclusion for cosmetic procedures
15789	Chemical peel, facial; dermal	Specific exclusion for cosmetic procedures
15792	Chemical peel, nonfacial; epidermal	Specific exclusion for cosmetic procedures
15793	Chemical peel, nonfacial; dermal	Specific exclusion for cosmetic procedures
15820	Blepharoplasty, lower eyelid	Specific exclusion for

NON-COVERED CODES: Cosmetic when performed as a component of gender reassignment surgery, even when coverage for gender reassignment surgery is approved		
Code	**Description**	**Benefit Plan Reference/ Reason**
		cosmetic procedures
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad	Specific exclusion for cosmetic procedures
15822	Blepharoplasty, upper eyelid	Specific exclusion for cosmetic procedures
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Specific exclusion for cosmetic procedures
15824	Rhytidectomy, forehead	Specific exclusion for cosmetic procedures
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Specific exclusion for cosmetic procedures
15826	Rhytidectomy; glabellar frown lines	Specific exclusion for cosmetic procedures
15828	Rhytidectomy; cheek, chin, and neck	Specific exclusion for cosmetic procedures
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Specific exclusion for cosmetic procedures
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Specific exclusion for cosmetic procedures
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Specific exclusion for cosmetic procedures
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Specific exclusion for cosmetic procedures
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Specific exclusion for cosmetic procedures
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Specific exclusion for cosmetic procedures
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Specific exclusion for cosmetic procedures
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Specific exclusion for cosmetic procedures
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Specific exclusion for cosmetic procedures
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Specific exclusion for cosmetic procedures
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	Specific exclusion for cosmetic procedures

NON-COVERED CODES: Cosmetic when performed as a component of gender reassignment surgery, even when coverage for gender reassignment surgery is approved		
Code	**Description**	**Benefit Plan Reference/ Reason**
15876	Suction assisted lipectomy; head and neck	Specific exclusion for cosmetic procedures
15877	Suction assisted lipectomy; trunk	Specific exclusion for cosmetic procedures
15878	Suction assisted lipectomy; upper extremity	Specific exclusion for cosmetic procedures
15879	Suction assisted lipectomy; lower extremity	Specific exclusion for cosmetic procedures
17380	Electrolysis epilation, each 30 minutes	Specific exclusion for cosmetic procedures
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue (Used to report calf, cheek, malar or pectoral implants or fat transfers in conjunction with gender reassignment surgery)	Specific exclusion for cosmetic procedures
19316	Mastopexy	Specific exclusion for cosmetic procedures
19324	Mammoplasty, augmentation; without prosthetic implant	Specific exclusion for cosmetic procedures
19325	Mammoplasty, augmentation; with prosthetic implant	Specific exclusion for cosmetic procedures
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Specific exclusion for cosmetic procedures
19342	Delayed insertion of breast prosthesis following mastopexy	Specific exclusion for cosmetic procedures
19350	Nipple/areola reconstruction	Specific exclusion for cosmetic procedures
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	Specific exclusion for cosmetic procedures
21121	Genioplasty; sliding osteotomy, single piece	Specific exclusion for cosmetic procedures
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	Specific exclusion for cosmetic procedures
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Specific exclusion for cosmetic procedures
21125	Augmentation, mandibular body or angle; prosthetic material	Specific exclusion for cosmetic procedures
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	Specific exclusion for cosmetic procedures
21137	Reduction forehead; contouring only	Specific exclusion for

NON-COVERED CODES: Cosmetic when performed as a component of gender reassignment surgery, even when coverage for gender reassignment surgery is approved		
Code	**Description**	**Benefit Plan Reference/ Reason**
		cosmetic procedures
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	Specific exclusion for cosmetic procedures
21270	Malar augmentation, prosthetic material	Specific exclusion for cosmetic procedures
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Specific exclusion for cosmetic procedures
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Specific exclusion for cosmetic procedures
30420	Rhinoplasty, primary; including major septal repair	Specific exclusion for cosmetic procedures
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Specific exclusion for cosmetic procedures
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Specific exclusion for cosmetic procedures
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Specific exclusion for cosmetic procedures
31599	Unlisted procedure, larynx (used to report laryngoplasty performed in conjunction with gender reassignment surgery)	Specific exclusion for cosmetic procedures
40799	Unlisted procedure, lips (used to report lip reduction/enhancement performed in conjunction with gender reassignment surgery)	Specific exclusion for cosmetic procedures
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	Specific exclusion for cosmetic procedures
54401	Insertion of penile prosthesis; inflatable (self-contained)	Specific exclusion for cosmetic procedures
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	Specific exclusion for cosmetic procedures
54660	Insertion of testicular prosthesis (separate procedure)	Specific exclusion for cosmetic procedures
55175	Scrotoplasty; simple	Specific exclusion for cosmetic procedures
55180	Scrotoplasty; complicated	Specific exclusion for cosmetic procedures
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Specific exclusion for cosmetic procedures

ICD-10 DIAGNOSIS CODES

Code	Description
F64.1	Gender identity disorder in adolescence and adulthood
F64.2	Gender identity disorder in childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

5.0 Unique Configuration/Prior Approval/Coverage Details:

All plans are federally mandated to cover gender reassignment treatment and are adopting the benefit on renewal throughout 2017. The State of Michigan is not enforcing the mandate due to pending litigation, but Health Plan is continuing to offer this benefit.

6.0 Terms & Definitions:

Female-to-Male Reassignment	Gender reassignment surgery from female to male (FTM) transsexual people includes genital surgical procedures that reshape a female body into the appearance of a male body. Breast or chest surgery, which may include subcutaneous mastectomy and/or creation of a male chest, may also be performed. Other non-genital non-breast related surgeries include but are not limited to liposuction, lipoprofiling, pectoral implants and other masculinizing procedures. An individual who is genetically female but whose gender identity is male, and who assumes a male gender presentation and role is known as a transman.
Male-to-Female Reassignment	Gender reassignment surgery from male-to-female (MTF) transsexuals includes genital procedures that shape a male body into the appearance of and, to the maximum extent possible, the function of a female body. Breast augmentation may be considered when 12 months of hormone treatment fails to result in breast enlargement that is sufficient for the individual's comfort in the female gender role. Breast surgery, which includes augmentation mammoplasty (implants/lipofilling), is a surgical procedure that may also be performed. In addition, other non-genital, non-breast related surgeries, often considered feminization procedures, may be performed. An individual who is genetically male but whose gender identity is female, and who assumes a female gender presentation and role is known as a transwoman.
Preservation of Fertility	Procedures aimed at preservation of fertility (e.g., procurement, cryopreservation, and storage of sperm, oocytes and/or embryos) performed prior to gender reassignment surgery are considered not medically necessary.
Qualified Mental Health Professional	At least one of the professionals submitting a letter must have a doctoral degree (e.g., Ph.D., M.D., Ed.D., D.SC., D.S.W., or Psy.D) or a master's level degree in a clinical behavior science field (e.g., M.S.W., L.C.S.W., Nurse Practitioner [N.P], Advanced Practice Nurse [A.P.R.N.], Licensed Professional Councilor [L.P.C.], and Marriage and Family Therapist [M.F.T]) and be capable of adequately evaluating co-morbid psychiatric conditions.
World Professional Association for Transgender Health [WPATH]	A professional organization devoted to the understanding and treatment of gender identity disorders. Promotes standards of health care for individuals through the articular of "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Seventh Version" (WPATH, 2013). This document is widely accepted as the definitive document in the area of gender dysphoria treatment. The WPATH criteria have been adopted in several countries as the standard of care for the treatment of gender dysphoria, including hormone therapy and sex reassignment

	surgery.

7.0 References, Citations & Resources:

1. Centers for Medicare & Medicaid Services, Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N). https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=282.
2. Fenway Health - Transgender Health Program (THP), The Medical Care of Transgender Persons, Fall 2015. Available at: http://www.lgbthealtheducation.org/publication/transgender-sod/.
3. International Journal of Transgenderism, Facial gender confirmation surgery-review of literature and recommendations for Version 8 of the WPATH Standards of Care. April 24, 2017. Available at: https://www.tandfonline.com/doi/abs/10.1080/15532739.2017.1302862
4. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Seventh Version, World Professional Association for Transgender Health (WPATH), 2013.

8.0 Associated Documents [For internal use only]:

Business Process Flow (BPF) –None.

Standard Operating Procedure (SOP) - MM-03 Benefit Determinations; MM-25 Transition/Continuity of Care; MM-55 Peer-to-Peer Conversations; MM-57 Coordination with External Entities; SOP 007 Algorithm for Use of Criteria for Benefit Determinations; SOP 016 Identification, Referral and Assignment of Members for Case Management Services.

Desk Level Procedure (DLP) – In process.

Sample Letter - TCS Approval Letter; Clinically Reviewed Exclusion Letter; Partial Coverage, Partial Non-Coverage Letter; Specific Exclusion Denial Letter.

Form - Request Form: Out of Network/Prior Authorization.

Other – None.

9.0 Revision History:

Original Effective Date: 01/01/2017

Last Approval Date: 01/14/2019

Next Revision Date: 01/14/2020

Revision Date	Reason for Revision
December 2016	Policy created
February 2017	Converted from Medical Policy 037 to Benefit Coverage policy (BCP) 24
November 2017	Annual review, references and websites updated
October 2018	Annual review by QI/MRM 12/12/18. No changes.