

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Medical and surgical treatments of gender dysphoria in transgender individuals involves psychotherapy, hormonal therapy and, in some cases, gender affirmation surgery.

Background

This policy supports applicable professional association statements,[1-5] and is also intended to support the Affordable Care Act (ACA) Section 1557 final implementing regulations published on May 18, 2016, and applicable state requirements[6].

Medical and Surgical Treatment of Gender Dysphoria

A clinical diagnosis of gender dysphoria is required prior to treatment of the disorder. Treatments typically include psychotherapy, hormone therapy and in some cases surgical gender affirmation procedures. Psychotherapy followed by hormone therapy is often the first medical treatment sought, although not all transgender individuals on hormone therapy choose to undergo gender-affirming surgery.[2]

Psychotherapy
Psychotherapy provided by a mental health professional typically includes an initial assessment of gender identity and dysphoria, the historical development of gender dysphoric feelings, and severity of resulting stress caused by the condition. The goal of therapy is to assess, diagnose, and discuss treatment options, if needed, and is typically required prior to hormone therapy and/or surgical treatment.

**Hormone Therapy**

Hormone therapy is undertaken in order to feminize or masculinize individuals’ bodies to conform to their desired gender identities. For transgender individuals, hormone replacement therapy (HRT) causes the development of many of the secondary sexual characteristics of their gender identity. Prescribed hormones differ depending upon the natal gender of the individual. For MTF individuals, hormone treatment may include estradiol, finasteride, and spironolactone. For FTM individuals, hormone treatment may include androgenic hormones such as testosterone.

**Surgical Treatment**

Surgical treatment for gender dysphoria differs depending upon the natal gender of the individual. For MTF individuals, surgery may involve removal of the testicles and penis and the creation of a pseudo vagina, clitoris, and labia. Complications of MTF genital surgery may include necrosis of the vagina and labia, neovaginal prolapse, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and small or short vaginas.

For FTM individuals, surgery may involve removal of the uterus, ovaries, and vagina, and creation of a neophallus and scrotum with scrotal and/or penile prostheses. The creation of a neophallus for FTM patients is a multistage reconstructive procedure. Currently, techniques for penile reconstruction procedures vary and complications may include frequent urinary tract stenoses and fistulas, donor site scarring and necrosis of the neophallus. In addition, breast size does not significantly decrease with hormonal therapy and as a result, FTM patients may choose to undergo mastectomy to remove breast tissue. For many patients this may be the only surgery undertaken. Mastectomy may involve a complete resection of all breast tissue; however, the nipple/areola sparing technique is typically performed to preserve the nipple/areola.

There are various additional aesthetic surgical procedures which may be sought in order to complete the physical gender transformation and align an individual to their gender identity. However, conflicting opinions exist regarding whether these procedures are essential in treating gender dysphoria.

The WPATH recommends that patients, “engage in 12 continuous months of living in a gender role that is congruent with their gender identity…” prior to gender reassignment surgery so that patients may socially adjust to their desired gender role. WPATH notes that changing a gender role may have personal and social consequences which should be adequately explored prior to undergoing an irreversible surgery.

**MEDICAL POLICY CRITERIA**

Note: Member contracts for covered services vary. Member contract language takes precedent over medical policy.
I. Medical Treatments of Gender Dysphoria

A. Psychotherapy may be considered **medically necessary** as a treatment of gender dysphoria

B. Continuous hormone therapy may be considered **medically necessary** as a treatment of gender dysphoria when all of the following criteria are met:

1. Clinical records document that the patient has the capacity to make fully informed decisions and consent for treatment; and

2. A licensed mental health professional has diagnosed gender dysphoria as defined by the DSM-5 criteria (see Appendix 1); and

3. At least one of the following criteria must be met for a period of 3 or more months prior to the initiation of hormone therapy:
   
   a. Documentation of living as the desired gender; and/or
   
   b. Psychotherapy with a licensed mental health professional.

II. Surgical Treatments of Gender Dysphoria may be considered **medically necessary** when either A. or B. are met:

A. Gender affirmation surgery (see Policy Guidelines) may be considered **medically necessary** in the treatment of gender dysphoria when all of the following criteria are met:

1. Age at least 18 years (Note: *age requirement will not be applied to mastectomy in Female-to-Male patients with documented provider determination of medical necessity of earlier intervention*); and

2. Clinical records document that the patient has the capacity to make fully informed decisions and consent for treatment, and that any other mental health condition, if present, is adequately controlled; and

3. At least 2 licensed mental health professionals have diagnosed gender dysphoria as defined by the DSM-5 criteria (see Appendix 1), and recommend surgical treatment (Note: *only 1 mental health professional referral is required for mastectomy in Female-To-Male patients*); and

4. Documentation of continuous hormonal therapy for at least 12 months, unless there is a documented contraindication to hormonal therapy (Note: *hormonal therapy is not required prior to mastectomy in Female-To-Male patients*); and

5. Twelve months of living in a gender role that is congruent with the patient’s gender identity.

B. When the criteria in II.A. above are met or have been met, the following procedures may be considered **medically necessary** when clinical information is submitted expressly
documenting that the particular requested procedure would improve otherwise documented significant gender dysphoria:

1. Breast augmentation
2. Hair removal
3. Hair transplantation
4. Nipple/areola reconstruction in the absence of concurrent or prior subcutaneous or simple/total mastectomy
5. Mastopexy

III. Other than gender affirmation surgeries listed in the Policy Guidelines, and/or surgeries in criteria II above, additional treatments to change specific appearance characteristics are considered **not medically necessary** as treatments of gender dysphoria including, but not limited to the following:

A. Abdominoplasty
B. Blepharoplasty
C. Brow lift
D. Calf implants
E. Cheek/malar implants
F. Chin/nose implants
G. Collagen injections
H. Face-lift
I. Facial bone reduction
J. Forehead lift
K. Lip reduction
L. Liposuction
M. Neck tightening
N. Pectoral implants
O. Reduction thyroid chondroplasty
P. Rhinoplasty
Q. Suction-assisted lipoplasty of the waist
POLICY GUIDELINES

Gender Affirmation Surgery

Surgical treatment for gender dysphoria differs depending upon the birth gender of the individual. The World Professional Association for Transgender Health (WPATH) indicated that, “(p)hysicians who perform surgical treatments for gender dysphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon.”[4]

Female-To-Male (FTM)

For females transitioning to males, the following procedures may be included as part of gender affirmation surgery:[4,8]

- Hysterectomy
- Mastectomy (subcutaneous mastectomy or simple/total mastectomy, which may include related nipple/areola reconstruction)
- Metoidioplasty
- Nipple/areola reconstruction related to subcutaneous or simple/total mastectomy with nipple/areola excision or repositioning
- Penile prostheses implantation
- Phallic reconstruction/Phalloplasty
- Salpingo-oophorectomy
- Scrotoplasty
- Testicular prostheses implantation
- Urethroplasty
- Vaginectomy

Definitions:

Subcutaneous mastectomy: skin-sparing mastectomy which removes tissue through an incision under the breast, leaving the skin, areola, and nipple intact.

Simple/total mastectomy: removal of the entire breast and commonly any excess skin, including the areola and nipple.
Male-To-Female (MTF)

For males transitioning to females, the following procedures may be included as part of gender affirmation surgery:[4]

- Clitoroplasty
- Labiaplasty
- Orchietomy
- Penectomy
- Vaginoplasty

SCIENTIFIC EVIDENCE

Evidence regarding the treatment of gender dysphoria in transgender individuals primarily consists of two systematic reviews consisting of small cohort studies. Randomized clinical trials (RCTs) comparing gender dysphoria treatments with the non-treatment are ideal, however, there are challenges in conducting RCTs to evaluate treatments of gender dysphoria due to several factors, such as small patient populations and ethical concerns regarding the high morbidity and mortality rates associated with non-treatment. Therefore, large RCTs are not anticipated. This policy relies on the following systematic reviews and non-randomized studies, as well as professional association recommendations to support applicable federal and state requirements.

Literature Appraisal

Systematic Reviews

Only one of two systematic reviews is considered good quality[9] (Murad et al.) and reported on the resolution of gender dysphoria psychiatric comorbidities, quality of life, and sexual satisfaction outcomes for individuals treated with both hormonal and surgical treatments for gender identity disorder (GID).

In 2009, Murad and colleagues assessed quality of life and other psychosocial outcomes of transgendered individuals with GID, receiving hormonal therapy as part of gender affirmation surgery.[9] Twenty-eight cohort studies were included in the review which included pooled data from 1,833 patients with GID (1,093 MTF and 801 FTM). Significant improvements were reported after gender affirmation compared to pre-treatment status: 80% of patients reported improvement in gender dysphoria (95% CI = 68-89%; 8 studies) 78% reported significant improvement in psychological symptoms (95% CI = 56-94%; 7 studies) 80% reported significant improvement in quality of life (95% CI = 72-88%; 16 studies); and 72% reported significant improvement in sexual function (95% CI = 60-81%; 15 studies). Significant study heterogeneity was reported for all outcomes. Although the authors acknowledge the low quality of evidence used in the analysis, gender affirmation that included hormonal interventions in patient with GID was thought to likely improve symptoms of gender dysphoria and overall quality of life.

In 2009, Elamin and colleagues evaluated the use of sex steroids on cardiovascular risk in transgender individuals.[10] A total of 16 studies were included in the review with a total of 1,471 male-to-female (MTF) patients and 651 female-to-male (FTM) patients. Steroid use was associated with increased serum triglycerides in both MTF and FTM patients and a nonsignificant effect on HDL-cholesterol and
systolic blood pressure in FTM patients. Authors noted that the quality of evidence was low due to methodological limitations of included studies, including but not limited to, heterogeneity of patient population and variable follow-up periods and uncontrolled study design.

**Nonrandomized Studies**

Primary evidence is limited to cohort studies with a variety of methodological limitations, including but not limited to small sample size, short-term follow-up, lack of comparison group, and varied treatment methods. Despite these limitations, significant improvements in quality of life, psychological comorbidities, and sexual functioning were consistently reported in patients who received gender-confirming medical treatments.[11]

Imbimbo et al., evaluated the clinical and psychosocial profile of male-to-female transgendered individuals who had undergone reconstructive surgery.[12] The average age of patients was 31 years old, 72% had high educational levels, half of patients’ contemplated suicide at some point prior to surgery and 4% had attempted suicide. Improved sex life satisfaction was reported in 75% of patients, with almost all patients’ reporting satisfaction with their new sexual status. Additional studies sought to evaluate the sociodemographic profile of transgender individuals with GID in an effort to better characterize and provide treatment for this population.[13]

Heylens and colleagues assessed comorbidities and psychosocial factors at various phases of the gender affirmation process in 57 patients with GID.[14] The Symptom Checklist-90 (SCL-90) was administered at three time points: baseline, after the start of hormone therapy, and after sex reassignment surgery (SRS) (also known as [aka] gender affirmation surgery). Psychopathological parameters include overall psychoneurotic distress, anxiety, agoraphobia, depression, somatization, paranoid ideation/psychoticism, interpersonal sensitivity, hostility, and sleeping problems and the psychosocial parameters consist of relationship, living situation, employment, sexual contacts, social contacts, substance abuse, and suicide attempt. The greatest improvement in psychoneurotic distress was observed after the initiation of hormone therapy (p<0.001). In addition, significant decreases in anxiety, depression, interpersonal sensitivity and hostility were reported after hormone therapy. No significant differences were observed in pre- and postoperative assessments.

Fisher et al. described clinical and sociodemographic features of 140 transmen (n=48) and transwomen (n=92) with GID and without affirmation surgery.[15] The following assessment tests were administered: the Body Uneasiness Test (a self-rating scale exploring different areas of body-related psychopathology), Symptom Checklist-90 Revised (a self-rating scale to measure psychological state), and the Bem Sex Role Inventory (a self-rating scale to evaluate gender role). Authors reported that transmen displayed significantly better social functioning than transwoman.

Gorin-Lazard et al. reported a case series which assessed a variety of gender dysphoria symptoms with hormonal treatment preceding gender affirmation surgery. Pre- and post- hormone treatment self-esteem (Social Self-Esteem Inventory), mood (Beck Depression Inventory), QoL (Subjective Quality of Life Analysis), and global functioning (Global Assessment of Functioning) scores were compared in 49 patients.[16] Hormone therapy was reported to be an independent factor in greater self-esteem, a reduction in depression, and improved QoL scores.

Gomez-Gil and colleagues evaluated symptoms of social distress, anxiety and depression in 187 transgendered individuals.[17] Of those included in the study, 120 had undergone hormonal sex-reassignment (SR) (aka gender affirmation) treatment and 67 had not. Social anxiety was assessed with
the Social Anxiety and Distress Scale (SADS) and depression and anxiety were assessed with the Hospital Anxiety and Depression Scale (HADS). The non-hormone group was reported to be significantly younger than the treatment group (mean age 25.9 vs. 33.6 years, p=0.001) and was less likely to have undergone surgical interventions (p<0.001). After adjusting for confounding factors, the authors reported that patients who were receiving hormone treatment had significantly lower prevalence of depression, anxiety, and social anxiety than those not receiving hormones.

Johansson et al., reported long-term (5-year) outcomes of transgendered individuals (n=42) with GID who had completely transitioned (n=32), were in progress (n=5) or who were on hormone therapy (n=5). Authors reported that no patient regretted affirmation and clinicians rated the global outcome as favorable in 62% of the cases, compared to 95% according to the patients themselves, with no differences between the subgroups. At follow-up, more than 90% of patients reported stable or improved work situations, partner relations and sex-life. However 5-15% of patients reported dissatisfaction with hormonal treatment, results of surgery, total gender affirmation procedure, or their present general health.

Asscheman and colleagues evaluated the long-term (1-year) effects of cross-sex hormones in 966 male-to-female (MTF) and 365 female-to-male (FTM) transgendered individuals. MTF patients received different doses of estrogen and cyproterone acetate and FTM patients received parenteral/oral testosterone esters or testosterone gel. Hormone treatment levels varied at pre-and post-surgical affirmation time points. High mortality rates were reported in the MTF group when compared to the general population (51%); however, this increased rate was due to non-hormone-related causes such as suicide, acquired immunodeficiency syndrome (AIDS), cardiovascular disease, drug abuse and other unknown causes. No significant increase in mortality was observed in FTM patients compared to the general population.

Clinical Practice Guidelines

World Professional Association for Transgender Health

The World Professional Association for Transgender Health (WPATH) is a multidisciplinary professional society representing the specialties of medicine, psychology, social sciences and law that has published clinical guidelines regarding health services for patients with gender disorders. In 2012, WPATH updated their evidence and consensus-based guideline regarding, the Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming Peoples. WPATH listed the following options for individuals seeking treatment for gender dysphoria:

- 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;
- 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.

WPATH guidelines describe surgical procedures as “irreversible changes to the body.” Therefore, WPATH guidelines recommend the appropriate care should be taken to ensure patients have sufficient time (at least 24 hours) to consider all the information and can provide informed consent. WPATH
notes, “(t)hese surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and patients share responsibility for the decision to make irreversible changes to the body.”

Physical Interventions for Adolescents

WPATH guidelines state that physical interventions for adolescents fall into three categories or stages:

1. Fully reversible interventions. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. Partially reversible interventions. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. Irreversible interventions. Reversible and irreversible interventions are outlined in the standards of care, specifying intervention sequencing in adolescents. It is also stated that “[t]wo goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.”

Referral for Surgery

WPATH guidelines indicate that surgical treatments can be initiated by a referral from a qualified mental health professional. One or two referrals may be required depending upon the type of surgery requested. “The mental health professional provides documentation—in the chart and/or referral letter—of the patient’s personal and treatment history, progress, and eligibility.” WPATH guidelines specifically recommend the following:

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).
- Two referrals—from qualified mental health professionals who have independently assessed the patient—are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries).

Criteria for Breast/Chest Surgery (One Referral)

WPATH lists the following criteria for mastectomy and creation of a male chest in FTM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

Criteria for Genital Surgery (Two Referrals)

WPATH lists the following criteria for genital surgery:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient’s gender goals (unless hormones are not clinically indicated for the individual).

In addition, WPATH made specific recommendations regarding breast augmentation procedures:

Breast Augmentation

The WPATH guideline recommends MTF patients undergo feminizing hormone therapy for a minimum of 12 months prior to augmentation surgery and lists specific criteria for breast augmentation (implants/lipofilling).

The Endocrine Society

In 2009, the Endocrine Society in conjunction with European Society of Endocrinology, European Society for Pediatric Endocrinology, Lawson Wilkins Pediatric Endocrine Society, and World Professional Association, published the only evidence-based guidelines regarding the treatment of transsexual persons. The guideline employed transparent methods for evidence review and for rating the quality of evidence. All recommendations were based upon evidence which was rated to be low quality. The consortium made the following recommendations:

Diagnostic Procedure

1. We recommend that the diagnosis of gender identity disorder (GID) be made by a mental health professional (MHP). For children and adolescents, the MHP should also have training in child and adolescent developmental psychopathology.
2. Given the high rate of remission of GID after the onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children with GID.
3. We recommend that physicians evaluate and ensure that applicants understand the reversible and irreversible effects of hormone suppression (e.g. GnRH analog treatment) and cross-sex hormone treatment before they start hormone treatment.
4. We recommend that all transsexual individuals be informed and counseled regarding options for fertility prior to initiation of puberty suppression in adolescents and prior to treatment with sex hormones of the desired sex in both adolescents and adults.

Treatment of Adolescents
1. We recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development.
2. We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively), but no earlier than Tanner stages 2–3.
3. We recommend that GnRH analogs be used to achieve suppression of pubertal hormones.
4. We suggest that pubertal development of the desired opposite sex be initiated at about the age of 16 year, using a gradually increasing dose schedule of cross-sex steroids.
5. We recommend referring hormone-treated adolescents for surgery when:
   a. the real-life experience (RLE) has resulted in a satisfactory social role change;
   b. the individual is satisfied about the hormonal effects; and
   c. the individual desires definitive surgical changes.
6. We suggest deferring surgery until the individual is at least 18 year old.

**Hormonal Therapy for Transsexual Adults**

1. We recommend that treating endocrinologists confirm the diagnostic criteria of GID or transsexualism and the eligibility and readiness criteria for the endocrine phase of gender transition.
2. We recommend that medical conditions that can be exacerbated by hormone depletion and cross-sex hormone treatment be evaluated and addressed prior to initiation of treatment.
3. We suggest that cross-sex hormone levels be maintained in the normal physiological range for the desired gender.
4. We suggest that endocrinologists review the onset and time course of physical changes induced by cross-sex hormone treatment.

**Adverse Outcome Prevention and Long-term Care**

1. We suggest regular clinical and laboratory monitoring every 3 months during the first year and then once or twice yearly.
2. We suggest monitoring prolactin levels in male-to-female (MTF) transsexual persons treated with estrogens.
3. We suggest that transsexual persons treated with hormones be evaluated for cardiovascular risk factors.
4. We suggest that bone mineral density (BMD) measurements be obtained if risk factors for osteoporosis exist, specifically in those who stop hormone therapy after gonadectomy.
5. We suggest that MTF transsexual persons who have no known increased risk of breast cancer follow breast screening guidelines recommended for biological women.
6. We suggest that MTF transsexual persons treated with estrogens follow screening guidelines for prostatic disease and prostate cancer recommended for biological men.
7. We suggest that female-to-male (FTM) transsexual persons evaluate the risks and benefits of including total hysterectomy and oophorectomy as part of sex reassignment surgery.

**Surgery for Sex Reassignment**

1. We recommend that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the MHP find surgery advisable.
2. We recommend that genital sex reassignment surgery be recommended only after completion of at least 1 year of consistent and compliant hormone treatment.
3. We recommend that the physician responsible for endocrine treatment medically clear transsexual individuals for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery.

**American College of Obstetricians and Gynecology**

In 2011, American College of Obstetricians and Gynecology (ACOG) published a committee opinion regarding health care services for transgendered individuals.[21] Although this guideline is not based in evidence, ACOG does make the following recommendations, “Obstetrician–gynecologists should be prepared to assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies. Hormonal and surgical therapies for transgender patients may be requested, but should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender patients.”

In addition, ACOG guidelines made specific recommendations regarding hormone therapy, surgery and screening for both female-to-male and male-to-female patients:

**Female-to-Male Transgender Individuals**

**Hormones**

Methyltestosterone injections every 2 weeks are usually sufficient to suppress menses and induce masculine secondary sex characteristics. Before receiving androgen therapy, patients should be screened for medical contraindications and have periodic laboratory testing, including hemoglobin and hematocrit to evaluate for polycythemia, liver function tests, and serum testosterone level assessments (goal is a mid-normal male range of 500 microgram/dL), while receiving the treatment.

**Surgery**

Hysterectomy, with or without salpingo-oophorectomy, is commonly part of the surgical process. An obstetrician–gynecologist who has no specialized expertise in transgender care may be asked to perform this surgery, and also may be consulted for routine reasons such as dysfunctional bleeding or pelvic pain. Reconstructive surgery should be performed by a urologist, gynecologist, plastic surgeon, or general surgeon who has specialized competence and training in this field.

**Screening**

Age-appropriate screening for breast cancer and cervical cancer should be continued unless mastectomy or removal of the cervix has occurred. For patients using androgen therapy who have not had a complete hysterectomy, there may be an increased risk of endometrial cancer and ovarian cancer.

**Male-to-Female Transgender Individuals**

**Hormones**

Estrogen therapy results in gynecomastia, reduced hair growth, redistribution of fat, and reduced testicular volume. All patients considering therapy should be screened for medical contraindications.
After surgery, doses of estradiol, 2–4 mg/d, or conjugated equine estrogen, 2.5 mg/d, are often sufficient to keep total testosterone levels to normal female levels of less than 25 ng/dL. Nonoral therapy also can be offered. It is recommended that male-to-female transgender patients receiving estrogen therapy have an annual prolactin level assessment and visual field examination to screen for prolactinoma.

**Surgery**

Surgery usually involves penile and testicular excision and the creation of a neovagina. Reported complications of surgery include vaginal and urethral stenosis, fistula formation, problems with remnants of erectile tissue, and pain. Vaginal dilation of the neovagina is required to maintain patency. Other surgical procedures that may be performed include breast implants and nongenital surgery, such as facial feminization surgery.

**Screening**

Age-appropriate screening for breast and prostate cancer is appropriate for male-to-female transgender patients. Opinion varies regarding the need for Pap testing in this population. In patients who have a neocervix created from the glans penis, routine cytologic examination of the neocervix may be indicated. The glands are more prone to cancerous changes than the skin of the penile shaft, and intraepithelial neoplasia of the glans is more likely to progress to invasive carcinoma than is intraepithelial neoplasia of other penile skin.

**Summary**

The research lacks well-designed studies comparing the safety and effectiveness of non-treatment for gender dysphoria with treatments such as hormone therapy and gender affirmation surgery. However, there are challenges in conducting large studies to evaluate existing treatments, and such studies are not expected in the near future. Although additional research is needed, the research has consistently suggested significant improvement in symptoms and overall quality of life in those who have received treatment for gender dysphoria. Therefore, treatment of gender dysphoria in transgender individuals may be considered medically necessary when specified policy criteria are met.

The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming Peoples describe reversible and irreversible interventions, and the ideal order and timing of these approaches. Surgery as an intervention is considered irreversible by WPATH. Therefore, reversal of gender affirmation surgery is considered not medically necessary as a treatment of gender dysphoria.

**REFERENCES**


5. Delegates, AMAHo. Resolution #114. American Medical Association House of Delegates. “Removing Barriers to Care for Transgender Patients” [cited; Available from:


**CROSS REFERENCES**

- Endometrial Ablation, Surgery, Policy No. 01
- Cosmetic and Reconstructive Surgery, Surgery, Policy No. 12
- Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants, Surgery, Policy No. 40
- Reduction Mammaplasty, Surgery, Policy No. 60
- Autologous Fat Grafting to the Breast and Adipose-derived Stem Cells, Surgery, Policy No. 182
- AndroGel®, AndroGel Pump® topical testosterone gel 1% and 1.62%, Medication Policy Manual, Policy No. dru360
- Testosterone replacement therapy products (Androderm®, Axiron®, Fortesta®, Striant®, Testim Gel®, Natesto™, Vogelxo™), Medication Policy Manual, Policy No. dru297
- finasteride 1 mg (generic, Propecia®), Medication Policy Manual, Policy No. dru474

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</tr>
<tr>
<td>53420</td>
<td>53420</td>
<td>Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage</td>
</tr>
<tr>
<td>53425</td>
<td>53425</td>
<td>Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage</td>
</tr>
<tr>
<td>53430</td>
<td>53430</td>
<td>Urethroplasty, reconstruction of female urethra</td>
</tr>
<tr>
<td>54125</td>
<td>54125</td>
<td>Amputation of penis; complete (Penectomy)</td>
</tr>
<tr>
<td>54520</td>
<td>54520</td>
<td>Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach</td>
</tr>
<tr>
<td>54660</td>
<td>54660</td>
<td>Insertion of testicular prosthesis</td>
</tr>
<tr>
<td>54690</td>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy</td>
</tr>
<tr>
<td>55175</td>
<td>55175</td>
<td>Scrotoplasty; simple</td>
</tr>
<tr>
<td>55180</td>
<td>55180</td>
<td>Scrotoplasty; complicated</td>
</tr>
<tr>
<td>55899</td>
<td>55899</td>
<td>Phallic reconstruction/Phalloplasty (Unlisted procedure, male genital system)</td>
</tr>
<tr>
<td>55970</td>
<td>55970</td>
<td>intersex surgery; male to female</td>
</tr>
<tr>
<td>CODES</td>
<td>NUMBER</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>-------</td>
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<td>-------------</td>
</tr>
<tr>
<td>55980</td>
<td></td>
<td>intersex surgery; female to male</td>
</tr>
<tr>
<td>56800</td>
<td></td>
<td>Plastic repair of introitus</td>
</tr>
<tr>
<td>56805</td>
<td></td>
<td>Clitoroplasty for intersex state</td>
</tr>
<tr>
<td>57106</td>
<td></td>
<td>Vaginectomy, partial removal of vaginal wall</td>
</tr>
<tr>
<td>57110</td>
<td></td>
<td>Vaginectomy, complete removal of vaginal wall;</td>
</tr>
<tr>
<td>57291</td>
<td></td>
<td>Construction of artificial vagina; without graft</td>
</tr>
<tr>
<td>57292</td>
<td></td>
<td>Construction of artificial vagina; with graft</td>
</tr>
<tr>
<td>57295</td>
<td></td>
<td>Revision (including removal) of prosthetic vaginal graft; vaginal approach</td>
</tr>
<tr>
<td>57296</td>
<td></td>
<td>Revision (including removal) of prosthetic vaginal graft; open abdominal approach</td>
</tr>
<tr>
<td>57335</td>
<td></td>
<td>Vaginoplasty for intersex state - the physician uses various plastic surgery techniques to correct a small, underdeveloped vagina due to the overproduction of male hormones</td>
</tr>
<tr>
<td>57426</td>
<td></td>
<td>Revision (including removal) of prosthetic vaginal graft, laparoscopic approach</td>
</tr>
<tr>
<td>58150</td>
<td></td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58180</td>
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<td>Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)</td>
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<tr>
<td>58260</td>
<td></td>
<td>Vaginal hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58262</td>
<td></td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)</td>
</tr>
<tr>
<td>58275</td>
<td></td>
<td>Vaginal hysterectomy, with total or partial vaginectomy;</td>
</tr>
<tr>
<td>58290</td>
<td></td>
<td>Vaginal hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58291</td>
<td></td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58541</td>
<td></td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58542</td>
<td></td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>CODES</td>
<td>NUMBER</td>
<td>DESCRIPTION</td>
</tr>
<tr>
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</tr>
<tr>
<td>57295</td>
<td></td>
<td>Revision (including removal) of prosthetic vaginal graft; vaginal approach</td>
</tr>
<tr>
<td>58543</td>
<td></td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58544</td>
<td></td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58550</td>
<td></td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58552</td>
<td></td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58553</td>
<td></td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58554</td>
<td></td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58570</td>
<td></td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58571</td>
<td></td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58572</td>
<td></td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58573</td>
<td></td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58720</td>
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<td>Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)</td>
</tr>
<tr>
<td>HCPCS</td>
<td>C1813</td>
<td>Prosthesis, penile, inflatable</td>
</tr>
<tr>
<td></td>
<td>L8039</td>
<td>Breast prosthesis, not otherwise specified</td>
</tr>
<tr>
<td></td>
<td>L8600</td>
<td>Implantable breast prosthesis, silicone or equal</td>
</tr>
</tbody>
</table>

**APPENDIX 1**

**Gender Dysphoria**[23]

Gender dysphoria is defined by the Diagnostic and Statistical Manual of Mental Disorders DSM-5V as:

*Gender Dysphoria in Children:*
A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender)
2. In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play of fantasy play.
4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 2.55.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen insensitivity syndrome)

Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults:

A. 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:

1. 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).
2. 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.)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender) or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. 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).
APPENDIX 1

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 2.55.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen insensitivity syndrome) Coding note: Code the disorder of sex development as well as gender dysphoria.

*Specify if:*

Post transition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender reassignment surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female).”