Title: Transgender Services

Description/Background

Gender dysphoria is classified as mental and emotional discomfort or distress caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (along with its associated gender role and/or primary and secondary sex characteristics). Gender dysphoria, referred to in the past as transsexualism, is defined as the strong desire to live as a member of the opposite sex. For individuals who experience gender dysphoria at a level that meets criteria for formal diagnosis, various treatment options are available.

ASSESSMENT / DIAGNOSIS

Adults

The mental health professional (MHP) who is making the diagnosis of GD in adults should meet the following criteria: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD and make a distinction between GD and conditions that have similar features, (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending professional meetings.

Children and Adolescents

Assessing gender dysphoria in children and adolescents is often an extremely complex process. The MHP who is diagnosing children or adolescents should have the same credentials as noted above for adults. In addition, the following is necessary: training and experience in child and adolescent gender development, as well as child and adolescent psychopathology; and, knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents.
Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. Specialty services may include endocrinology, adolescent medicine, surgery, urology, gynecology, and behavioral health specialists (psychiatrist, psychologist, social worker). If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions regarding physical interventions.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults.

A gender dysphoria diagnosis in adolescents and adults involves a difference between one’s experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least 6 months and is shown by at least two of the following:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one’s primary and/or 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
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least 6 months.

1. A strong desire to be of the other gender or an insistence that one is the other gender
2. A strong preference for wearing clothes typical of the opposite gender
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. A strong rejection of toys, games and activities typical of one’s assigned gender
7. A strong dislike of one’s sexual anatomy
8. A strong desire for the physical sex characteristics that match one’s experienced gender

Gender atypical behavior is common among young children and may be part of normal development. For many children who meet the criteria for gender dysphoria, the feelings do not continue into adolescence and adulthood.

**TREATMENT**

Following a clinical diagnosis of gender dysphoria, a variety of treatment options may be considered. While many individuals require hormone therapy and surgery to alleviate their gender dysphoria, others may need only one of these treatment options and some require neither. Some individuals are able to integrate their feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others,
changes in gender role and expression alleviate gender dysphoria. The therapeutic approach to gender dysphoria must be individualized and may include one or more of the following options:

- Psychotherapy/counseling (individual, couple, family or group)
- 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); also defined as social transitioning
- Puberty suppression in adolescents
- Hormone therapy to feminize or masculinize the body
- Gender Affirming surgery to change primary and/or secondary sex characteristics

**Psychotherapy/Counseling**
Mental health professionals play an important role in working with individuals with gender dysphoria. They can provide accurate diagnosis of gender disorder and any co-morbid psychiatric conditions, counsel patients regarding the various options available to alleviate gender dysphoria, provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. Once the patient is evaluated, the mental health professional may need to provide documentation and formal recommendations for hormonal and surgical treatment.

Mental health services may be delivered by a range of provider types including psychiatrists, psychologists, practitioners with a master’s degree in social work (MSW), or licensed mental health counselors. However, the evaluations required for the prior authorization for gender affirming surgery must be performed by psychiatrists, PhD prepared psychologists or master’s prepared clinicians who are licensed to practice independently in their state.

**Social Transitioning**
A change in gender expression and role (which may involve living part time or full time in another gender role consistent with one’s gender identity) assists both the individual and the clinician in determining how to proceed with treatment. During social transitioning, the individual’s feelings about the social transformation, including coping with the responses of others, is a major focus of the counseling. Optimal timing for social transitioning differs for each individual.

**Puberty Suppression**
Puberty suppression by means of gonadotropin releasing hormone (GnRH) analogs is considered a treatment option for gender dysphoric adolescents. The purpose of this intervention is to relieve the suffering caused by the development of secondary sex characteristics and to provide time to make a balanced decision regarding actual gender affirming. The use of puberty suppressing hormones may facilitate transition by preventing development of sex characteristics that are difficult or impossible to reverse by gender affirming surgery. It is recommended that adolescents experience the onset of puberty to at least Tanner stage 2 before suppression therapy is initiated.

**Hormone Therapy**
Feminizing/masculinizing hormone therapy produces physical changes that are more congruent with a patient’s gender identity. The goals of hormone therapy are to suppress the endogenous hormones of the patient’s natal sex and induce the secondary sex characteristics of the individual’s desired gender. Once this has been accomplished, the goal is to maintain cross-sex
hormone levels in the normal physiological range of the desired gender identity. Most of the physical changes will occur over the course of two years. The amount of change and exact timeline of the effects can be highly variable.

**Gender Affirming Surgery**

Gender affirming requires complex processes involving multiple medical, psychiatric, and surgical modalities working in combination to achieve successful behavioral and medical outcomes. Genital surgery is often the last and the most considered step in the treatment process for gender dysphoria. Depending on the surgery, patients may be required to engage in social transitioning to the desired gender role, and complete 12 months of hormone therapy before becoming eligible to undergo gender affirming surgery.

As a result of the complexity, irreversible nature and need to establish standards of care for gender affirming surgery, medical providers have come together to develop clinical guidelines that are used in the standardization of treatment decisions related to gender dysphoria.

The Standards of Care (7th version, 2011), published by The World Professional Association for Transgender Health (WPATH), are recognized as the most current set of clinical guidelines used in the treatment and management of Gender Dysphoria. WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, (HBIGDA) is recognized as the professional organization dedicated to the understanding and treatment of gender dysphoria. The organization’s primary mission is devoted to the advancement of both understanding and treatment of persons diagnosed with gender dysphoria.

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**Regulatory Status**

N/A

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**Medical Policy Statement**

The safety and effectiveness of selected medical and surgical treatments of gender dysphoria have been established. The established treatments of gender dysphoria include:

- Puberty suppression in adolescents
- Hormone therapy (for masculinization/feminization)
- Medically necessary gender affirming surgery*:
  - Genitalia reconstruction
  - Mastectomy in biological female-to-male transitions

(*Gender affirming surgery may require prior authorization.)

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

- Breast cancer screening for biological female-to-male transitioned persons who have not undergone a mastectomy.
- Prostate cancer screening for biological male-to-female transitioned persons who have retained their prostate.
• Cervical screening for biological female-to-male transitioned persons, as needed.
• Obstetric services in biological female-to-male transitioned persons.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

For University of Michigan Gender-Affirming Services (facial feminization, hair removal or chondrolaryngoplasty), please reference the Medical Policy Partner Document.

Assessment, diagnosis and treatment should be provided through a multidisciplinary gender services clinic/program affiliated with a major medical center. If this level of service is unavailable, there should be documentation that reflects a coordinated approach to care by specialists involved (mental health specialists, physicians, surgeons, etc.).

**PUBERTY SUPPRESSION**

**Puberty suppression** hormones for adolescents may be indicated for members that meet all of the following inclusionary criteria:

**Inclusions:**
- Onset of puberty to at least Tanner stage 2;
- The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
- Gender dysphoria emerged or worsened with the onset of puberty;
- Any coexisting psychological, medical or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent’s situation and functioning are stable enough to start treatment;
- The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents/guardians or other legally authorized caretakers have consented to the treatment and are involved in supporting the adolescent throughout the treatment process;
- The absence of contraindications to therapy in the judgment of the managing physician.

*Medications for puberty suppression may be managed under the member’s pharmacy benefit.

**HORMONE THERAPY**

**Hormone therapy** may be indicated for members that meet all of the following inclusionary criteria:

**Inclusions:**
- Persistent, well-documented gender dysphoria;
- Capacity to make a fully informed decision and to consent for treatments;
- 18 years of age or older (age of majority);
- If significant medical or mental health concerns are present, they must be reasonably well-controlled;
- The absence of contraindications to therapy in the judgment of the managing physician.

*Medications for hormone therapy may be managed under the member’s pharmacy benefit.
GENDER AFFIRMING SURGERY

**Gender affirming surgery** may be indicated for members that meet all of the following inclusionary criteria:

**Inclusions:**
- Persistent, well-documented gender dysphoria;
- The provider must supply documentation that supports the member meets criteria for gender affirming surgery:
  - For mastectomy in biological female-to-male patients, or for gender affirming surgery:
    - A (one) detailed psychological assessment by a mental health provider: either a psychiatrist, PhD prepared clinical psychologist or master’s prepared clinician who is licensed to practice independently in their state and has experience with gender dysphoria; and,
    - The psychological evaluation must be performed within a year of the surgery;
- 18 years of age or older;
- Capacity to make a fully informed decision and to consent for treatment;
- If significant medical or mental health concerns are present, they must be controlled;
- 12 continuous months of hormone therapy* as appropriate to the patient’s gender role (unless there is a contraindication to hormonal therapy);
  - *Hormonal therapy is NOT required prior to mastectomy in biological female-to-male patients
  - The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.
- 12 continuous months of living in a gender role that is congruent with their gender identity.
  - Living in a gender role congruent with gender identity for 12 continuous months is NOT required prior to mastectomy in biological female-to-male patients

**Electrolysis**
- If gender affirming surgery is approved for a biological male transitioning to female, permanent hair removal (by electrolysis) may be considered established following medical review. Permanent hair removal is considered established only when the scrotal and surrounding tissues are used in the surgical construction of the vagina.
- If gender affirming surgery is approved for a biological female transitioning to male, permanent hair removal (by electrolysis) may be considered established following medical review. Permanent hair removal is considered established only when free flap, or other donor tissues, are used for phalloplasty performed in conjunction with vaginectomy and full-length urethroplasty.

Some patients receiving transgender services may require and benefit from ongoing behavioral health services, including psychotherapy.

**Exclusions:**
- Transgender services are not covered if contract or certificate language contains specific exclusion of these services.
- Reversal of transgender surgical procedures.
• All procedures that are primarily cosmetic and not medically necessary including but not limited to*:
  o Abdominoplasty
  o Blepharoplasty
  o Breast enhancements
  o Brow lift
  o Calf implants
  o Cheek/malar implants
  o Chin/nose implants
  o Chondrolaryngoplasty (Adam’s apple reduction)
  o Collagen injections
  o Drugs for hair loss or growth
  o Forehead lift
  o Hair removal (for exception: see Inclusions, Electrolysis)
  o Hair transplantation
  o Lip reduction
  o Liposuction
  o Mastopexy
  o Neck tightening
  o Pectoral implants
  o Removal of redundant skin
  o Rhinoplasty
  o Speech-language therapy
  o Non-covered services

• Facial Feminization Surgery AND Facial Masculinization Surgery are considered cosmetic and not medically necessary. Some procedures are listed above but the list is not all-inclusive.

* For University of Michigan Gender-Affirming Services (facial feminization, hair removal or chondrolaryngoplasty), please reference the Medical Policy Partner Document.

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**CPT/HCPCS Level II Codes** *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

**Established codes:**

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*17380 may be considered established when performed to prepare tissues prior to genital surgery—see inclusions

**Other codes (investigational, not medically necessary, etc.):**

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NOTE: Medication codes for puberty suppression and hormone therapy may be managed under the member’s pharmacy benefit.

**Note:** Codes may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.

**Note:** Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.

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**Rationale**

For individuals seeking care for gender dysphoria (GD), a variety of therapeutic options can be considered. Treatment typically includes psychotherapy, hormone therapy and in some cases gender affirming surgery. Not everyone with GD needs or wants all elements.

**Puberty Suppression**

Puberty suppression by means of gonadotropin-releasing hormone analogs has become accepted in clinical management of adolescents who have gender dysphoria. Evidence from observational studies suggests that suppression of endogenous puberty may help to alleviate psychosocial distress in gender dysphoric adolescents.

In a prospective follow-up study of 70 adolescents with gender dysphoria comparing psychological functioning before and after puberty suppression, it was concluded that puberty suppression may be considered a valuable contribution in clinical management. Behavioral and emotional problems along with depressive symptoms decreased, while general functioning improved significantly during puberty suppression.

A longer-term follow-up on 55 young transgender adults who received puberty suppression during adolescence were assessed 3 times (before the start of puberty suppression, when cross-sex hormones were introduced and at least 1 year after gender affirming surgery). It was concluded that a clinical protocol of a multidisciplinary team with mental health professionals, physicians and surgeons, including puberty suppression, followed by cross-sex hormones and gender affirming surgery, provides gender dysphoric youth who seek gender affirming from early puberty on, the opportunity to develop into well-functioning young adults.

The Endocrine Society Clinical Practice Guideline (2009) conclusions are as follows: “Transsexual persons seeking to develop the physical characteristics of the desired gender require a safe, effective hormone regimen that will 1) suppress endogenous hormone secretion determined by the person’s genetic/biologic sex and 2) maintain sex hormone levels within the
normal range for the person’s desired gender. A mental health professional (MHP) must recommend endocrine treatment and participate in ongoing care throughout the endocrine transition and decision for surgical gender affirming. The endocrinologist must confirm the diagnostic criteria the MHP used to make these recommendations. Because a diagnosis of transsexualism in a prepubertal child cannot be made with certainty, we do not recommend endocrine treatment of prepubertal children. We recommend treating transsexual adolescents (Tanner stage 2) by suppressing puberty with GnRH analogues until age 16 years old, after which cross-sex hormones may be given. We suggest suppressing endogenous sex hormones, maintaining physiologic levels of gender-appropriate sex hormones and monitoring for known risks in adult transsexual persons.”

**Hormone Therapy**

A number of studies of cross-hormone therapy each show positive findings resulting in improvement of well-being, quality of life and self-fulfillment after feminization/masculinization hormone therapy. Some individuals may need a change in gender role along with hormone therapy while others may need both hormone therapy and gender affirming surgery to alleviate gender dysphoria.

**Gender Affirming**

Gender affirming surgery is often the last step in the treatment process for GD. This may be essential for relief from GD that cannot be achieved without surgical modification of their primary and/or secondary sex characteristics. Mental health professionals, surgeons and the patients share responsibility to decide if gender affirming surgery is the appropriate treatment option.

**Systematic Review**

One systematic review reported on the resolution of GD 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 et al published a systematic review evaluating the effects of endocrine interventions as part of gender affirming in male-to-female or female-to-male individuals. Twenty-eight observational studies were included in the review (1,833 participants). Significant improvements were reported after gender affirming compared to pre-treatment status. 80% of patients reported improvement in GD (95% CI = 69-89%; 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 affirming surgery that included hormonal interventions in patients with GID* was thought to likely improve GD, psychological functioning and comorbidities, sexual function and overall quality of life.

**Nonrandomized Studies**

Johansson (2009) et al reported a 5 year outcomes study of 42 transgendered individuals 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 their reassignment. The clinicians
rated the global outcome as favorable in 62% of the cases, compared to 95% according to patients themselves, with no differences between subgroups. Based on the follow-up interview, more than 90% were stable or improved as regards to work situation, partner relations and sex life, but 5-15% were dissatisfied with the hormonal treatment, results of surgery, total gender affirming procedure, or their present general health. Most outcome measures were rated positive and substantially equal for male-to-female and female-to-male. In conclusion, almost all patients were satisfied with the gender affirming; 86% were assessed by clinicians at follow-up as stable or improved global functioning.

In 2005, Smith et al prospectively studied 162 adults to evaluate gender affirming as treatment for gender dysphoria. Results suggest that subjective measures of GD, body satisfaction and psychological function were improved following surgery. The majority of patients (98%) did not regret the surgery, 92% were satisfied with their overall appearance, and most (82%) were sexually active, however, 18% of sexually active patients reported being unable to achieve orgasm. The author concluded that the results substantiate previous conclusions that gender affirming is effective.

While many transsexual, transgender and gender-nonconforming individuals find comfort with their gender identity, role and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria. “Follow-up studies have shown an undeniable beneficial effect of gender affirming surgery on postoperative outcomes such as subjective well-being, cosmesis and sexual function (De Cuypere et al, 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfafflin & Junge, 1998).”

*Note: Gender Identity Disorder (GID) was the term used prior to the current preferred diagnostic term Gender Dysphoria.

**Summary**

Suppression of endogenous puberty may be warranted for adolescents (Tanner stage 2) diagnosed with gender dysphoria. It has become an accepted practice in the management of gender dysphoric adolescents and may help to alleviate psychosocial distress and improve overall functioning. Endocrine treatment of prepubertal children is not recommended.

Feminization/masculinization hormone therapy studies have shown an overall improvement in well-being for individuals with gender dysphoria. Some individuals may require both hormone therapy and gender affirming surgery to alleviate gender dysphoria.

Overall, studies have been reporting that gender affirming surgery is effective with outcomes reporting improvement in psychological function, quality of life and sexual function.

**Supplemental Information**

**Practice Guidelines and Position Statements**

The World Professional Association for Transgender Health (WPATH)
WPATH is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health.
WPATH seeks to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The most current publication is the 7th version, approved in 2011.

Two goals justify intervention with puberty-suppressing hormones:
- Their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and
- 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 gender affirming.

Feminizing/masculinizing hormone therapy is a medically necessary intervention for many individuals with gender dysphoria. Some seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics.

For some individuals, gender affirming surgery may be essential and medically necessary to alleviate gender dysphoria to establish greater congruence with their gender identity.

**The American College of Obstetricians and Gynecologists (ACOG)**
**Committee Opinion – Health Care for Transgender Individuals, 512, December 2011**
- The American College of Obstetricians and Gynecologists urges health care providers to foster nondiscriminatory practices and policies to increase identification and to facilitate quality health care for transgender individuals, both in assisting with the transition if desired as well as providing long-term preventive health care."

**Committee Opinion – Care for Transgender Adolescents, 685 (Reaffirmed 2020), January 2017**

**Recommendations and Conclusions:**
The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:
- Obstetricians-gynecologists should understand gender identity and be able to treat transgender patients or refer them appropriately for medical and surgical therapeutic options.
- A patient with gender dysphoria may first present to a gynecologist: therefore, it is important for the clinician to be aware of this condition.
- Obstetrician-gynecologists can provide referrals as well as support and resources to young patients.
- It is important for obstetrician-gynecologists to be aware of the social and mental health risks for the transgender population.
- Transgender male adolescents have a uterus, ovaries, and breast tissue and, thus, can develop medical complications of gynecologic organs and also become pregnant.
- The need to discuss fertility preservation before initiation of cross-sex hormones is another important reason that obstetrician-gynecologists may be involved in the care of transgender adolescents.
- Like all patients, transgender adolescents should have a source of ongoing primary care.

**American Psychiatric Association’s Position Statement on Access to Care for Transgender and Gender Variant Individuals, 2012, Revised 2018**
The American Psychiatric Association:
• Recognizes that appropriately evaluated transgender and gender diverse individuals can benefit greatly from medical and surgical gender-affirming treatments.
• Advocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment.
• Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.
• Supports evidenced-based coverage of all gender-affirming procedures which would help the mental well-being of gender diverse individuals.

Endocrine Society

Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 2017

Puberty suppression
Recommendations:
• Given the high rate of remission of GID after onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children with GID.
• Adolescents who fulfill eligibility and readiness criteria for gender affirming initially undergo treatment to suppress pubertal development.
• Suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty, but no earlier than Tanner stages 2-3.
• GnRH analogs be used to achieve suppression of pubertal hormones.
• Referring hormone-treated adolescents for surgery when 1) the real-life experience has resulted in satisfactory social role change; 2) the individual is satisfied about the hormonal effects; and 3) the individual desires definitive surgical changes.

Suggestions:
• Pubertal development of the desired opposite sex be initiated at about the age of 16, using a gradually increasing dose schedule of cross-sex hormones.
• Deferring surgery until the individual is at least 18 years old.

Hormone Therapy
Recommendations:
• Treating endocrinologists confirm the diagnostic criteria of GD/gender incongruence and eligibility and readiness criteria for the endocrine phase of gender transition.
• Medical conditions that can be exacerbated by hormone depletion and cross-sex hormone treatment be evaluated and addressed prior to initiation of treatment.

Suggestions:
• Cross-sex hormone levels be measured to ensure they are maintained in the normal physiological range for desired gender.
• Endocrinologists provide education to those undergoing treatment about the onset and time course of physical changes induced by cross-sex hormone treatment.

Surgery for gender affirming
Recommendations:
• Consider gender affirming surgery only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery to be advisable.
• Genital gender affirming surgery approved only after completion of at least 1 year of consistent and compliant hormone treatment.
• The physician responsible for endocrine treatment and the primary care provider medically clear transsexual individuals for gender affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery.

**Government Regulations**

**National:**

National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9)
Effective Date of this Version 8/30/2016
Implementation Date 4/4/2017

Benefit Category: Physicians’ Services

Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Item/Service Description
A. General
Gender reassignment surgery is a general term to describe a surgery or surgeries that affirm a person's gender identity.

Indications and Limitations of Coverage
B. Nationally Covered Indications
N/A
C. Nationally Non-Covered Indications
N/A
D. Other
The Centers for Medicare & Medicaid Coverage (CMS) conducted a National Coverage Analysis that focused on the topic of gender reassignment surgery. Effective August 30, 2016, after examining the medical evidence, CMS determined that no national coverage determination (NCD) is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with gender dysphoria. In the absence of an NCD, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.
(This policy last reviewed August 2016.)

**Local:**

There are no LCDs on related topics.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicaid Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)
Related Policies

N/A

References

17. The Academy College of Obstetricians and Gynecologist (ACOG), Care for transgender adolescents, Committee Opinion No. 685, Obstet Gynecol 2017 (Reaffirmed 2020); 129:e11-16.

*The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through January, 2021, the date the research was completed.*
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<td></td>
<td>One mental health eval for mastectomy or gender affirming surgery, within one year of procedure.</td>
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<td></td>
<td>Addition of OB services to MPS.</td>
</tr>
<tr>
<td>5/1/21</td>
<td>2/16/21</td>
<td>Routine maintenance. Updated phrases “gender reassignment” and “sex reassignment” to “gender affirming”. Added “biological” prior to female-to-male and male-to-female phrases. Added code 19318. Added under exclusion: Facial Feminization Surgery AND Facial Masculinization Surgery are considered cosmetic and not medically necessary. Some procedures are listed above but the list is not all-inclusive.</td>
<td></td>
</tr>
</tbody>
</table>

**Next Review Date:** 1st Qtr, 2022
I. Coverage Determination:

<table>
<thead>
<tr>
<th>Commercial HMO (includes Self-Funded groups unless otherwise specified)</th>
<th>Covered; policy criteria apply. Transgender services are not covered if the contract or certificate language contains specific exclusions of these services. For University of Michigan Gender-Affirming Services (facial feminization, hair removal or chondrolaryngoplasty), please reference the Medical Policy Partner Document.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCNA (Medicare Advantage)</td>
<td>See Government Regulations section.</td>
</tr>
<tr>
<td>BCN65 (Medicare Complementary)</td>
<td>Coinsurance covered if primary Medicare covers the service.</td>
</tr>
</tbody>
</table>

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member’s certificate and is not guaranteed. Please consult the individual member’s certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.