Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

***Current Policy Effective Date: 1/1/23**
(See policy history boxes for previous effective dates)

Title: Gender Affirming 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). For individuals who experience gender dysphoria at a level that meets criteria for formal diagnosis, various gender affirming treatment options are available.

The term transgender is used to describe people whose gender identities and/or gender expressions are not what is typically expected for the sex to which they were assigned at birth. The term gender diverse is used to describe people with gender identities and/or expressions that are different from social and cultural expectations attributed to their sex assigned at birth. This may include, among many other culturally diverse identities, people who identify as nonbinary, gender expansive, gender nonconforming, and others who do not identify as cisgender.

Available data indicate that transgender and gender diverse people represent a small but growing proportion of the general population. Based on the credible evidence available to date, this proportion may range from a fraction of a percent to several percentage points depending on the inclusion criteria, age group, and geographic location. [1]

In the management of gender dysphoria it is mandatory to correctly diagnose the condition and then choose appropriate health care professionals to manage the medical and surgical interventions that may be appropriate.

ASSESSMENT / DIAGNOSIS

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 a second criteria for adolescents and adults.

Children

Gender atypical behavior is common among young children and may be part of normal development. For many children diagnosed with gender dysphoria, the feelings do not continue into adolescence and adulthood. Children are not the focus of this policy.

Adolescents and Adults

A gender dysphoria diagnosis in adolescents, defined as from the start of puberty until the legal age of majority (18 years of age), and adults involves a marked difference between one's experienced/expressed gender and assigned gender for at least six months' duration. This condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning 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

HEALTH CARE PROFESSIONALS

Adolescents

Diagnosing gender dysphoria in adolescents is often an extremely complex process. The health care professional (HCP) who is working with gender diverse adolescents should meet **ALL** of the following criteria:

1. Are licensed by their professional body and hold a postgraduate degree or its equivalent in a clinical field related to transgender health granted by an accredited institution **and**
2. Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum **and**
3. Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span **and**
4. Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.

Among HCPs, the mental health professional (MHP) has the most appropriate training and dedicated clinical time to conduct an assessment and elucidate treatment priorities and goals when working with transgender youth, including those seeking gender-affirming medical care. [1]

Heath care professionals taking care of transgender and gender diverse adolescents should involve relevant disciplines, including mental health and medical professionals to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

Adults

Health care professionals assessing transgender and gender diverse adults for gender-affirming medical and/or surgical treatments (GAMSTs) should meet **ALL** of the following criteria:

1. Are licensed by their professional body and hold, at a minimum, a master's degree or equivalent training in a clinical field related to transgender health or equivalent further clinical training in this area and granted by an accredited institution **and**
2. Should be competent using the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for diagnosis **and**
3. Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity **and**
4. Are able to assess capacity to consent for treatment **and**
5. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity **and**
6. Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.

TRANSITION

Transition is the process whereby people usually change from the gender expression associated with their assigned sex at birth to another gender expression that better matches their gender identity. People may transition socially by using methods such as changing their name, pronoun, clothing, hair styles, and/or the ways that they move and speak. Transitioning may or may not involve hormones and/or surgeries to alter the physical body. Transition can assist both the individual and the clinician in determining how to proceed with the individuals gender care needs. During transition, the individual's feelings about the transition, including coping with the responses of others, is a major focus of the counseling. Social transition can be extremely beneficial to many transgender and gender diverse people although not all transgender and gender diverse people are able to socially transition or wish to socially transition.

SUPPORT SERVICES

Medical, surgical, and psychosocial support for transgender and gender diverse individuals is often provided by a multi-disciplinary team. The health care professionals working together to care for transgender and gender diverse individuals may include disciplines within the following fields: endocrinology, adolescent or adult medicine, general surgery, urology, gynecology, plastic surgery, and behavioral health specialists (i.e. psychiatrist, psychologist, social worker).

Following a clinical diagnosis of gender dysphoria, a variety of services are available. 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. 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

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.

Hormone Therapy and Surgery

Puberty Suppression

Puberty suppression by means of gonadotropin releasing hormone (GnRH) agonists 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 steps. 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 (secondary sex characteristics) 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 procedures require complex processes involving multiple medical, psychiatric, and surgical modalities working in combination to achieve successful behavioral and medical outcomes. Depending on the surgery and age of the individual, patients may be required to engage in transitioning to the desired gender role, and complete 12 months of hormone therapy before becoming eligible to undergo gender affirming surgery. The term reconstructive in this medical policy refers to procedures intended to address a significant variation from normal related to disease or treatment of a disease.

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 World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, public policy, and respect in transgender health. One of the main functions of WPATH is to promote the highest standards of health care for transgender and gender diverse people through the Standards of Care (SOC). The SOC was initially developed in 1979 and the last version (SOC-7) was published in 2012. [2] In view of the increasing scientific evidence, WPATH commissioned a new version of the Standards of Care, the SOC-8. The Standards of Care (8th version, 2022), published by (WPATH), are recognized as the most current set of clinical guidelines used in the treatment and management of Gender Dysphoria.[1]

Regulatory Status

N/A

Medical Policy Statement

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

- Puberty suppression in adolescents
- Hormone therapy (for masculinization/feminization) for adolescents who meet criteria, and adults.
- Medically necessary gender affirming surgery*:
  - Genitalia reconstruction
  - Mastectomy for a transgender man (a person who has a gender identity as a man and who was assigned female at birth)
  - Augmentation mammoplasty (implants) for transgender women (a person who has a gender identity as a woman and who was assigned male at birth)
  - Thyroid reduction chondroplasty (tracheal shave)
  - Facial Feminization
  - Facial Masculinization

(*Gender affirming surgery may require prior authorization.)

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

- Breast cancer screening in transgender and gender diverse people with breasts from natal puberty who have not undergone gender-affirming chest surgery and for transgender and gender diverse people who have received estrogens, taking into account the length of time of hormone use, dosing, current age, and age at which the hormones were initiated.
- Prostate cancer screening for transgender and gender diverse persons who have retained their prostate.

- Cervical screening for transgender and gender diverse persons who currently have or previously had a cervix following local guidelines for cisgender women.
- Obstetric services for transgender and gender diverse persons when they are pregnant.
- To guide preventive medical care, any anatomical structure present that warrants screening should be screened, regardless of gender identity.

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

While the following procedures are considered established for this policy, the specific coverage for each member is based on the benefit, which is defined by the group or employer.

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*

Health care professionals taking care of transgender and gender diverse adolescents should involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for these adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care. Puberty suppression hormones for adolescents may be indicated for members that meet **ALL** of the following inclusionary criteria:

Inclusions:

- Meets diagnostic criteria for gender dysphoria (see Description/Background above for diagnostic criteria); **and**
- Gender dysphoria is marked and sustained; **and**
- Demonstrates emotional and cognitive maturity required to provide informed consent for the treatment; 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; **and**
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally; **and**
- Onset of puberty to at least Tanner stage 2 has been reached; **and**
- 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 for Adolescents, defined as from the start of puberty until the legal age of majority (18 years of age):

- Meets diagnostic criteria for gender dysphoria (see Description/Background above for diagnostic criteria); **and**
- Gender dysphoria is marked and sustained; **and**
- Demonstrates emotional and cognitive maturity required to provide informed consent for the treatment; 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; **and**
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally; **and**
- Onset of puberty to at least Tanner stage 2 has been reached; **and**
- The absence of contraindications to therapy in the judgment of the managing physician; **and**
- One letter of assessment as indicated below***; **and**
- Medications will be prescribed by or in consultation with a pediatric endocrinologist that has collaborated care with a mental health care provider for members less than 18 years of age.

Inclusions for Adults:

- 18 years of age or older (age of majority); **and**
- Meets diagnostic criteria for gender dysphoria (see Description/Background above for diagnostic criteria); **and**
- Gender dysphoria is marked and sustained; **and**
- Other possible causes of apparent gender incongruence have been identified and excluded; **and**
- Demonstrates capacity to make a fully informed decision and to consent for gender-affirming hormone treatment; **and**
- The absence of contraindications to therapy in the judgment of the managing physician; **and**
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed, with the risks and benefits discussed, before a decision is made regarding treatment.

*Medications for hormone therapy may be managed under the member's pharmacy benefit.

HAIR REMOVAL

- If gender affirming surgery is approved for a transgender or gender diverse person, hair removal (e.g., electrolysis, laser hair removal) may be considered established following medical review.
    - Hair removal is considered established only when the scrotal and surrounding tissues are used in the surgical construction of the vagina.
    - 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.

GENDER AFFIRMING SURGERY

Inclusions:

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

1. **Chest surgery****

    a. Mastectomy is considered **reconstructive** when **ALL** of the following criteria have been met:

    - The individual is at least 18 years of age; **and**
    - The individual has been diagnosed with gender dysphoria (see Description/Background section for diagnostic criteria); **and**
    - Gender dysphoria is marked and sustained; **and**
    - The individual has capacity to make fully informed decisions and consent for treatment; **and**
    - One letter of assessment as indicated below***; **and**
    - Other possible causes of apparent gender incongruence have been identified and excluded; **and**
    - Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed, with the risks and benefits discussed, before a decision is made regarding treatment; **and**
    - Hormone therapy prior to mastectomy is not required as the aim of hormone therapy prior to facial surgery or gonadectomy is primarily to introduce a period of reversible testosterone or estrogen suppression before the individual undergoes irreversible surgical intervention; **and**
    - Living in a gender role congruent with gender identity for 12 continuous months is not required prior to a mastectomy; **and**
    - Pre-operative and post-operative care that addresses **both** surgical results and possible behavioral health results is highly recommended.

    Nipple reconstruction, including tattooing, following a gender affirming mastectomy that meets the reconstructive criteria above is considered **reconstructive.**

    b. Breast augmentation is considered **reconstructive** when **ALL** of the following criteria have been met:

    - The individual is at least 18 years of age; **and**

- The individual has been diagnosed with gender dysphoria (see Description/Background section for diagnostic criteria); **and**
- Gender dysphoria is marked and sustained; **and**
- The individual has capacity to make fully informed decisions and consent for treatment; **and**
- One letter of assessment as indicated below***; **and**
- Other possible causes of apparent gender incongruence have been identified and excluded; **and**
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed, with the risks and benefits discussed, before a decision is made regarding treatment; **and**
- The individual is stable on their gender affirming hormonal treatment regime for at least 12 months, unless a rationale is provided by the HCP that indicates that hormone treatment is either contraindicated or not necessary for the individual's clinical situation; **and**
- Living in a gender role congruent with gender identity for 12 continuous months is not required prior to breast augmentation; **and**
- Existing chest appearance demonstrates significant variation from normal appearance for the experienced gender; **and**
  Pre-operative and post-operative care that addresses **both** surgical results and possible behavioral health results is highly recommended.

**The procedures needed to reconstruct a feminine/masculine appearance can only be performed once per lifetime.

2. **Facial surgery**** † is considered **reconstructive** when **ALL** of the following criteria have been met:

   - The individual is at least 18 years of age; **and**
   - The individual has been diagnosed with gender dysphoria (see Description/Background section for diagnostic criteria); **and**
   - Gender dysphoria is marked and sustained; **and**
   - The individual has capacity to make fully informed decisions and consent for treatment; **and**
   - Other possible causes of apparent gender incongruence have been identified and excluded; **and**
   - One letter of assessment as indicated below***; **and**
   - Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed, with the risks and benefits discussed, before a decision is made regarding treatment; **and**
   - The individual is stable on their gender affirming hormonal treatment regime for at least 12 months, unless a rationale is provided by the HCP that indicates that hormone treatment is either contraindicated or not necessary for the individual's clinical situation; **and**
   - The new gender identity should be present for at least 12 months; **and**
   - The member has a consistent stable gender identity that is well documented by their treating providers and when possible lives as their affirmed gender in places where it is safe to do so; **and**

- Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; **and**
- The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); **and**
- Pre-operative and post-operative care that addresses **both** surgical results and possible behavioral health results is highly recommended.

**The procedures needed to reconstruct a feminine/masculine appearance can only be performed once per lifetime.

†List of procedures included in this group is: Thyroid reduction chondroplasty (tracheal shave), genioplasty (repositioning or reshaping of the chin), mandible augmentation (jawline contouring/reconstruction), facial bone reduction, forehead reduction/contouring, rhinoplasty (reshaping/contouring of the nose).

3. **Genital surgery** is considered **medically necessary** when **ALL** of the following criteria have been met:

    - The individual is at least 18 years of age; **and**
    - The individual has been diagnosed with gender dysphoria (see Description/Background section for diagnostic criteria); **and**
    - Gender dysphoria is marked and sustained; **and**
    - The individual has capacity to make fully informed decisions and consent for treatment; **and**
    - Other possible causes of apparent gender incongruence have been identified and excluded; **and**
    - One letter of assessment as indicated below***; **and**
    - Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed, with the risks and benefits discussed, before a decision is made regarding treatment; **and**
    - The individual is stable on their gender affirming hormonal treatment regime for at least 12 months, unless a rationale is provided by the HCP that indicates that hormone treatment is either contraindicated or not necessary for the individual's clinical situation; **and**
    - The new gender identity should be present for at least 12 months; **and**
    - The member has a consistent stable gender identity that is well documented by their treating providers and when possible, lives as their affirmed gender in places where it is safe to do so; **and**
    - Pre-operative and post-operative care that addresses **both** surgical results and possible behavioral health results is highly recommended.

    These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

*****LETTER REQUIREMENTS:**

A. Required for hormone therapy for adolescents
B. Required for facial, pelvic, gonadal and/or genital surgery for adults

Adolescents

One letter of assessment from the multidisciplinary team (or in situations where a multidisciplinary team is not available, a professional from one of the multiple disciplines who are experts in transgender health and in the management of the care required for transgender and gender diverse adolescents who is taking care of the individual) is required for adolescents receiving gender-affirming medical treatment. This letter needs to reflect the assessment and opinion from the team, that involves **both** medical HCPs and mental health professionals, supports that the individual meets the criteria for gender dysphoria. The detailed assessment must have been performed within 12 months of the requested submission.

The HCP assessing and working with the adolescent should meet **ALL** of the following criteria:

1. Are licensed by their professional body and hold a postgraduate degree or its equivalent in a clinical field related to transgender health granted by a nationally accredited institution **and**
2. Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum **and**
3. Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span **and**
4. Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.

Adults

One letter of assessment from a HCP who has competencies in the assessment of transgender and gender diverse people documenting the individual meets the criteria for gender dysphoria is required for transgender and gender diverse adults who meet the below criteria for gender-affirming medical and surgical treatments. The detailed assessment must have been performed within 12 months of the requested submission.

The HCP should meet **ALL** of the following criteria:

1. Are licensed by their professional body and hold, at a minimum, a master's degree or equivalent training in a clinical field related to transgender health or equivalent further clinical training in this area and granted by a nationally accredited institution **and**
2. Should be competent using the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for diagnosis **and**
3. Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity **and**
4. Are able to assess capacity to consent for treatment **and**
5. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity **and**
6. Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.

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 reconstructive and/or not medically necessary including but not limited to:
  - Abdominoplasty
  - Blepharoplasty
  - Brow lift
  - Calf implants
  - Cheek/malar implants
  - Chin/nose implants
  - Collagen injections
  - Drugs for hair loss or growth
  - Forehead lift
  - Hair removal (for exception: see Inclusions, Electrolysis)
  - Hair transplantation
  - Injectable dermal fillers (i.e. Sculptra, Radiesse)
  - Lip reduction
  - Liposuction
  - Mastopexy
  - Neck tightening
  - Otoplasty
  - Pectoral implants
  - Removal of redundant skin
  - Rhytidectomy
  - Speech-language therapy
  - Non-covered services

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.)*

While the following procedures are considered established for this policy, the specific coverage for each member is based on the benefit, which is defined by the group or employer.

Established codes:

11920	11921	11922	17380*	17999*	19303
19318	19325	19350	21120	21121	21122
21123	21125	21127	21137	21138	21139
21209	30400	30410	30420	31599	31899
54520	55970	55980	56805	57291	57292
57335	58150	58152	58180	58260	58262
58275	58291	58541	58542	58543	58544

58550	58552	58553	58554		

*17380 and 17999 may be considered established only when performed to prepare tissues prior to genital surgery in conjunction with procedure codes 55970, 55980, 57291, 57292, or 57335.

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

11950	11951	11952	11954	15769	15771
15772	15773	15774	15820	15821	15822
15823	15824	15825	15826	15828	15830
15832	15833	15834	15835	15836	15837
15838	15839	15876	15877	15878	15879
19316	21208	30430	30435	30450	69300
Q2026	Q2028				

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.

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.

de Vries (2011) et al published 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. [3] Behavioral and emotional problems along with depressive symptoms decreased, while general functioning improved significantly during puberty suppression.

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.

Heylens (2014) assessed comorbidities and psychosocial factors at various phases of the gender affirmation process in 57 patients with gender identify disorder (GID).[4] 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 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.

Gorin-Lazard (2013) reported a case series which assessed a variety of gender dysphoria symptoms with hormonal treatment preceding gender affirmation surgery.[5] 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. Hormone therapy was reported to be an independent factor in greater self-esteem, a reduction in depression, and improved QoL scores.

de Vries (2014) et al was a long term follow-up study that followed 55 youth from early adolescence (pretreatment, mean age of 13.6) when cross-sex hormones were introduced (mean age, 16.7 years), and at least 1 year after gender reassignment surgery (mean age, 20.7 years).[6] Psychological functioning gender dysphoria (GD), body image, global functioning, depression, anxiety, emotional and behavioral problems) and objective (social and educational/professional functioning) and subjective (quality of life, satisfaction with life and happiness) well-being were investigated. The study found that after gender reassignment, in young adulthood, the GD was alleviated and psychological functioning had steadily improved. Well-being was similar to or better than same-age young adults from the general population. Improvements in psychological functioning were positively correlated with postsurgical subjective well-being. A clinical protocol of a multidisciplinary team with mental health professionals, physicians, and surgeons, including puberty suppression, followed by cross-sex hormones and gender reassignment surgery, provides gender dysphoric youth who seek gender reassignment from early puberty on, the opportunity to develop into well-functioning young adults.

Kuper (2020) et al published a longitudinal study followed and evaluated 148 participants receiving gender-affirming hormone therapy. [7] Participants completed surveys assessing body dissatisfaction (Body Image Scale), depression (Quick Inventory of Depressive Symptoms), and anxiety (Screen for Child Anxiety Related Emotional Disorders) at initial presentation to the clinic and at follow-up. Clinicians completed the Quick Inventory of Depressive Symptoms and collected information on youth experiences of suicidal ideation, suicide attempt, and NSSI. Affirmed males reported greater depression and anxiety at baseline, but these differences were small (P < .01). Youth reported large improvements in body dissatisfaction (P < .001),

small to moderate improvements in self-report of depressive symptoms (P < .001), and small improvements in total anxiety symptoms (P < .01). No demographic or treatment-related characteristics were associated with change over time. Lifetime and follow-up rates were 81% and 39% for suicidal ideation, 16% and 4% for suicide attempt, and 52% and 18% for NSSI, respectively. Results provide further evidence of the critical role of gender-affirming hormone therapy in reducing body dissatisfaction. Modest initial improvements in mental health were also evident.

Gender Affirming Surgery

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). [8] 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

Morrison (2020) et al performed a prospective, international, multicenter cohort study to assess outcomes of facial feminization surgery. [9] Outcomes reported were facial feminization outcome scores, satisfaction, and cephalometric analysis of femininity. A total of 66 consecutive patients at two clinics were enrolled. The increase in median facial feminization score from pre- to six months post-surgery was statistically significant, from 47.2 to 80.6 ($p<0.0001$). Cephalometric measures, including glabellar angle, nasolabial angle, and forehead inclination, were significantly more feminine after surgery. Mean satisfaction, measured on a five-point Likert scale, was 3.0 at <1-month post-surgery and six months post-surgery.

Raffaini (2016) et al performed a retrospective cohort study of 33 patients between 19 and 40 years of age were referred for facial feminization surgery between January of 2003 and December of 2013, for a total of 180 procedures. [10] Surgical outcome was analyzed both subjectively through questionnaires administered to patients and objectively by serial photographs. The study found that patient satisfaction after facial feminization surgery is high.

The reduction of gender dysphoria has psychological and social benefits and significantly affects patient outcome.

Ainsworth and Spiegel (2010) performed a cross-sectional study to determine the self-reported quality of life of male-to-female (MTF) transgendered individuals and how this quality of life is influenced by facial feminization and gender reassignment surgery. [11] Outcomes reported were mental health-related quality of life was statistically diminished ($P < 0.05$) in transgendered women without surgical intervention compared to the general female population and transwomen who had gender reassignment surgery (GRS), facial feminization surgery (FFS), or both. There was no statistically significant difference in the mental health-related quality of life among transgendered women who had GRS, FFS, or both. Participants who had FFS scored statistically higher ($P < 0.01$) than those who did not in the FFS outcomes evaluation. In conclusion, transwomen have diminished mental health-related quality of life compared with the general female population. However, surgical treatments (e.g. FFS, GRS, or both) are associated with improved mental health-related quality of life.

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). [12] 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. [13] 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.

For breast augmentation surgery, a prospective, noncomparative, cohort study Weigert et al, (2013)[14] found that gains in breast satisfaction, psychosocial well-being, and sexual well-being after male-to-female transsexual patients underwent breast augmentation were statistically significant and clinically meaningful to the patient at 4 months after surgery and in the long term. A retrospective cohort Fakin et al, (2019) [15] reported a consistent and direct improvement in patient satisfaction, including general satisfaction, body image satisfaction, and body image following surgery.

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). [16-19]

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

Summary

Suppression of endogenous puberty and treatment with hormone therapy may be warranted for adolescents (Tanner stage 2) diagnosed with gender dysphoria. They have 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 adult individuals with gender dysphoria. Some adult 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 Transgender and Gender Diverse People.* The most current publication is the 8th version, approved in 2022. [1]

WPATH SOC Version 8 uses “we recommend” as a strong recommendation based upon high quality evidence. They use “we suggest” as a weak recommendation based upon weak quality evidence.

Hormone Therapy

Statements of Recommendations

12.1- We recommend health care professionals begin pubertal hormone suppression in eligible* transgender and gender diverse adolescents after they first exhibit physical changes of puberty (Tanner stage 2).

12.2- We recommend health care professionals use gonadotropin releasing hormone (GnRH) agonists to suppress endogenous sex hormones in eligible* transgender and gender diverse people for whom puberty blocking is indicated.

12.3- We suggest health care professionals prescribe progestins (oral or injectable depot) for pubertal suspension in eligible* transgender and gender diverse youth when GnRH agonists are either not available or are cost prohibitive.

12.4- We suggest health care professionals prescribe GnRH agonists for suppression of sex steroids without concomitant sex steroid hormone replacement in eligible* transgender and gender diverse adolescents seeking such intervention and who are well into or have completed pubertal development (past Tanner stage 3) but are either unsure about or do not want to begin sex steroid hormone therapy.

12.5- We recommend health care professionals prescribe sex hormone treatment regimens as part of gender-affirming treatment for eligible* transgender and gender diverse adolescents who are at least Tanner stage 2, with parental/guardian involvement unless their involvement is determined to be harmful or unnecessary to the adolescent.

12.6- We recommend health care professionals measure hormone levels during gender-affirming treatment to ensure endogenous sex steroids are lowered and administered sex steroids are maintained at levels appropriate for the treatment goals of transgender and gender diverse people according to the Tanner stage.

12.7- We recommend health care professionals prescribe progestogens or a GnRH agonist for eligible* transgender and gender diverse adolescents with a uterus to reduce dysphoria caused by their menstrual cycle when gender-affirming testosterone use is not yet indicated.

12.8- We recommend health care providers involve professionals from multiple disciplines who are experts in transgender health and in the management of the care required for transgender and gender diverse adolescents.

12.9- We recommend health care professionals institute regular clinical evaluations for physical changes and potential adverse reactions to sex steroid hormones, including laboratory monitoring of sex steroid hormones every 3 months during the first year of hormone therapy or with dose changes until stable adult dosing is reached followed by clinical and laboratory testing once or twice a year once an adult maintenance dose is attained.

12.10- We recommend health care professionals inform and counsel all individuals seeking gender-affirming medical treatment about the options available for fertility preservation prior to initiating puberty suppression and prior to treating with hormone therapy.

12.11- We recommend health care professionals evaluate and address medical conditions that can be exacerbated by lowered endogenous sex hormone concentrations and treatment with exogenous sex hormones before beginning treatment for transgender and gender diverse people.

12.12- We recommend health care professionals educate transgender and gender diverse people undergoing gender-affirming treatment about the onset and time course of the physical changes induced by sex hormonal treatment.

12.13- We recommend health care professionals not prescribe ethinyl estradiol for transgender and gender diverse people as part of a gender-affirming hormonal treatment.

12.14- We suggest health care professionals prescribe transdermal estrogen for eligible* transgender and gender diverse people at higher risk of developing venous thromboembolism based on age > 45 years or a previous history of venous thromboembolism, when gender-affirming estrogen treatment is recommended.

12.15- We suggest health care professionals not prescribe conjugated estrogens in transgender and gender diverse people when estradiol is available as a component of gender-affirming hormonal treatment.

12.16- We recommend health care professionals prescribe testosterone-lowering medications (either cyproterone acetate, spironolactone, or GnRH agonists) for eligible* transgender and gender diverse people with testes who are taking estrogen as part of a hormonal treatment plan if the individual's goal is to approximate circulating sex hormone concentrations in cisgender women.

12.17- We recommend health care professionals monitor hematocrit (or hemoglobin) in transgender and gender diverse people treated with testosterone.

12.18- We suggest health care professionals collaborate with surgeons regarding hormone use before and after gender-affirmation surgery.

12.19- We suggest health care professionals counsel transgender and gender diverse people about the various options available for gender-affirmation surgery unless surgery is not indicated or is medically contraindicated.

12.20- We recommend health care professionals initiate and continue gender-affirming hormone therapy for eligible* transgender and gender diverse people who require this treatment due to demonstrated improvement in psychosocial functioning and quality of life.

12.21- We recommend health care professionals maintain existing hormone therapy if the transgender and gender diverse individual's mental health deteriorates and assess the reason for the deterioration, unless contraindicated.

Representative surgical interventions include:
Assigned male at birth (AMAB): facial feminization surgery (including chondrolaryngoplasty/vocal cord surgery), gender-affirming breast surgery, body contouring procedures, orchiectomy, vagino/vulvoplasty (with/without depth), aesthetic procedures, and procedures designed to prepare individuals for surgery (i.e., hair removal).

Assigned female at birth (AFAB): facial masculinization surgery, gender-affirming chest surgery, hysterectomy/oophorectomy, metoidioplasty (including placement of testicular prosthesis), phalloplasty (including placement of testicular/penile prostheses), body contouring procedures, aesthetic procedures, and procedures designed to prepare individuals for surgery (i.e., hair removal).

American Society of Plastic Surgeons (ASPS) May 2020
The ASPS is the largest organization of board-certified plastic surgeons in the world. Representing more than 7,000 physician members, the society is recognized as a leading authority and information source on cosmetic and reconstructive plastic surgery. [20]

- Facial feminization surgery is one of the fastest-growing areas in plastic surgery, and is increasingly recognized as a medically necessary treatment for gender dysphoria.

The American College of Obstetricians and Gynecologists (ACOG)
Committee Opinion – Health Care for Transgender Individuals, 512, December 2011.
Number 823 (Replaces Committee Opinion 512), March 2021
The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity, urges public and private health insurance plans to cover necessary services for individuals with gender dysphoria, and advocates for inclusive, thoughtful, and affirming care for transgender individuals. [21]

- Obstetrician–gynecologists should make their offices inclusive and inviting to all individuals who need obstetric or gynecologic health care. They should take steps to educate themselves and their medical teams about appropriate language and the health care needs of transgender patients.
- Fertility and parenting desires should be discussed early in the process of transition, before the initiation of hormone therapy or gender affirmation surgery.
- Gender-affirming hormone therapy is not effective contraception. Sexually active individuals with retained gonads who do not wish to become pregnant or cause pregnancy in others should be counseled about the possibility of pregnancy if they are having sexual activity that involves sperm and oocytes.
- The majority of medications used for gender transition are common and can be safely prescribed by a wide variety of health care professionals with appropriate training and education, including, but not limited to, obstetrician–gynecologists, family or internal medicine physicians, endocrinologists, advanced practice clinicians, and psychiatrists.
- Hysterectomy with or without bilateral salpingo-oophorectomy is medically necessary for patients with gender dysphoria who desire this procedure.
- To guide preventive medical care, any anatomical structure present that warrants screening should be screened, regardless of gender identity.

American Psychiatric Association's Position Statement on Access to Care for Transgender and Gender Variant Individuals, 2012, Revised 2018
The American Psychiatric Association: [22]

- 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 [23]

Puberty suppression

Recommendations:

- We recommend against puberty blocking and gender-affirming hormone treatment in pre-pubertal children with GD/gender incongruence.
- We recommend that clinicians inform and counsel all individuals seeking gender-affirming
- medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults.
- We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones.

Suggestions:

- We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development.
- We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty.

Hormone Therapy

Recommendations:

- In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years.
- We recognize that there may be compelling reasons to initiate sex hormone treatment prior
- to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥ 16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment.
- We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment.
- We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy.

Suggestions:

- We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment.
- We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender.
- We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment.
- We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly.
- We suggest periodically monitoring prolactin levels in transgender females treated with estrogens.
- We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools.

Surgery for gender affirming

Recommendations:

- We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being.
- We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes.

Suggestions:

- We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country.
- We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement.

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 & Medicare 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

1. The World Professional Association for Transgender Health (WPATH), “Standards of Care for the Health of Transgender and Gender Diverse People, 8th version, 2022.
2. The World Professional Association for Transgender Health (WPATH), “Standards of care for the health of transsexual, transgender and gender nonconforming people, 7th version,” 2012.
3. de Vries, Annelou L C et al. “Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study.” The journal of sexual medicine vol. 8,8 (2011): 2276-83. doi:10.1111/j.1743-6109.2010.01943.x

4. Heylens, G., Elaut, E., Kreukels, B. P. C., Paap, M. C. S., Cerwenka, S., Richter-Appelt, H., Cohen-Kettenis, P. T., Haraldsen, I. R., & De Cuypere, G. (2014). Psychiatric characteristics in transsexual individuals: Multicentre study in four European countries. British Journal of Psychiatry, 204(2), 151–156. https://doi.org/10.1192/bjp.bp.112.121954.
5. Gorin-Lazard, A., Baumstarck, K., Boyer, L., Maquigneau, A., Penochet, J. C., Pringuey, D., & Auquier, P. (2013). Hormonal therapy is associated with better self-esteem, mood, and quality of life in transsexuals. The Journal of Nervous and Mental Disease, 201(11), 996–1000. https:// doi.org/10.1097/nmd.0000000000000046.
6. de Vries, A.L., McGuire, J.K., Steensma, T.D., et al. "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment", PEDIATRICS, 134(4), 2014, pp. 696-704.
7. Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. Pediatrics, 145(4). https://doi.org/10.1542/peds.2019-3006.
8. Murad, M., Elamin, M.B., Garcia, M.Z., et al. "Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes", Clinical Endocrinology, 72(2), 2010, pp. 214-231.
9. Morrison, S.D., Capitán-Cañadas, F., Sánchez-García, A., et al. "Prospective Quality-of-Life Outcomes after Facial Feminization Surgery: An International Multicenter Study" *Plastic and Reconstructive Surgery*: 2020;145(6):1499-509. PMID: 32459779
10. Raffaini, M., Magri, A. S., & Agostini, T. (2016). Full facial feminization surgery: Patient satisfaction assessment based on 180 procedures involving 33 consecutive patients. Plastic and Reconstructive Surgery, 137(2), 438–448. https://doi.org/10.1097/01.prs.0000475754.71333.f6.
11. Ainsworth TA, Spiegel JH. Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. Qual Life Res. 2010; 19(7):1019-24.
12. Johannsson, A. & Höjerback, T., "A five-year follow-up study of Swedish adults with gender identity disorder", Arch Sex Behav, 39(6),2009, pp. 1429-1437.
13. Smith, Y.L., Van Goozen, S.H., Kuiper, A.J., et al. "Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals", Psychol Med, 35(1), 2005, pp. 89-99.
14. Weigert, R., Frison, E., Sessiecq, Q., Al Mutairi, K., & Casoli, V. (2013). Patient satisfaction with breasts and psychosocial, sexual, and physical well-being after breast augmentation in male-to-female transsexuals. Plastic Reconstructive Surgery, 132(6), 1421–1429. https://doi.org/10.1097/01.prs.0000434415.70711.49.
15. Fakin, R. M., Zimmermann, S., Kaye, K., Lunger, L., Weinforth, G., & Giovanoli, P. (2019). Long-term outcomes in breast augmentation in trans-women: A 20-year experience. Aesthetic Surgery Journal, 39(4), 381–390. https://doi.org/10.1093/asj/sjy143.
16. De Cuypere, G., T'Sjoen, G., Selvaggi, G., et al. "Sexual and physical health after sex reassignment surgery", Arch Sex Behav, Vol. 34, No. 6, 2005, pp. 679-690.
17. Gijs, L. & Brawaeys, A., "Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness and challenges", Annual Review of Sex Research, Vol. 18, 2006, pp. 178-184.
18. Klein, C. & Gorzalka, B., "Sexual functioning in transsexuals following hormone therapy and genital surgery: A Review", Journal of Sex Med, Vol. 6, No. 11, 2009, pp. 2922-2939.

19. Pfäfflin, F., & Junge, A. (1998). Sex reassignment: Thirty years of international follow-up studies. A comprehensive review, 1961–1991. International Journal of Transgenderism. http://www.symposion.com/ijt/books/index.htm.
20. American Society of Plastic Surgeons (ASPS). 2020 Position statement on facial feminization surgery. https://www.plasticsurgery.org/news/press-releases/new-study-evaluates-facial-feminization-outcomes-benefits-for-transgender-women
21. The Academy College of Obstetricians and Gynecologists (ACOG), Health care for transgender individuals, Committee Opinion No. 512, Obstet Gynecol 2011;118:1454-1458.
22. American Psychiatric Association. (2018) Position statement on access to care for transgender and gender diverse individuals.
23. Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., et al. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," J Clin Encrinol Metab, 102(11), 2017, pp. 3869-3903.
24. Cohen-Kettenis, P. "Transsexualism: a review of etiology, diagnosis and treatment," Journal of Psychosomatic Research, Vol. 46, No. 4, 1999, pp. 315-333.
25. Meyer-Bahlburg, H., "Introduction: gender dysphoria and gender change in persons with intersexuality," Archives of Sexual Behavior, Vol. 34, No. 4, 2005, pp. 371-373.
26. Tugnet, N., "Current management of male-to-female gender identity disorder in the UK," Postgraduate Medical Journal, Vol. 83, No. 984, 2007, pp. 638-642
27. Olson-Kennedy, J., Forcier, M., "Overview of the management of gender nonconformity in children and adolescents", UpToDate, literature review through March 2016, topic updated April 4, 2016.
28. Centers for Medicare and Medicaid Services, "NCD for Gender Dysphoria and Gender Reassignment Surgery (140.9), Publications Number 100-3, Effective date 8/30/2016, Implementation date 4/4/2017.
29. Hayes Medical Technology Directory, "Sex Reassignment Surgery and Associated Therapies for the Treatment of Gender Identity Disorder, Lansdale, PA: HAYES, Inc., December 1, 2004, last update July 27, 2022.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 10/12/22, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
5/1/16	2/16/16	5/23/16	Joint policy established
5/1/17	2/21/17	2/21/17	Routine maintenance
5/1/18	3/16/18	3/13/18	Routine maintenance; master's prepared clinician licensed to practice independently in state may provide evaluation for gender affirming surgery; require 2 mental health evaluations prior to surgery; clarified that female-to-male mastectomy does not require living in gender role for 12 continuous months; electrolysis may be established in preparation of tissues for male-to-female genital surgery; care should be through a multidisciplinary clinic or through a coordinated approach.
5/1/19	2/19/19		Routine maintenance Electrolysis for female-to-male genital surgery added to inclusions; construction of clitoral hood removed from exclusions.
5/1/20	2/18/20		Routine maintenance. Clarification re: puberty suppression in those with legal caretakers. Clarification in exclusions re: procedures excluded ("surgical" removed from text). Removed code 19318. One mental health eval for mastectomy or gender affirming surgery, within one year of procedure. Addition of OB services to MPS.

5/1/21	2/16/21		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.
5/1/22	2/15/22		Routine maintenance Guidelines updated
1/1/23	11/21/22		Routine maintenance WPATH SOC Version 8: published online September 15, 2022. Policy name changed from Transgender Services to Gender Affirming Services Added the below to MPS under Medically necessary gender affirming surgery for adults: • Augmentation mammoplasty (implants) for transgender women (a person who has a gender identity as a woman and who was assigned male at birth) • Thyroid reduction chondroplasty (tracheal shave) • Facial Feminization • Facial Masculinization Added codes to EST: 11920, 11921, 11922, 19325, 21137, 21138, 21139, 31599 Moved codes from Exclusion to EST: 15820, 15821, 15822, 15823, 21120, 21121, 21122, 21123, 21125, 21127, 30400, 30410, 30420 Added under Exclusions: • Added Mastopexy **code** 19316 under Exclusion

			• Added Otoplasty and code 69300 under Exclusion • Added Injectable dermal fillers (i.e. Sculptra, Radiesse) Q2026, Q2028 under Exclusion • Added Rhytidectomy under exclusion but codes are already on the policy • Added under Inclusions: • Added code 17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue (when used for laser hair removal) may be considered established when performed to prepare tissues prior to genital surgery – see inclusions (ky) Post JUMP changes: •Added 31899 Unlisted procedure, trachea, bronchi (when specified as reduction of thyroid cartilage/chondrolaryngoplasty [Reduction of the Adam's Apple]) to EST •Moved codes 17380 and 17999 from investigational to EST with * denoting 17380 and 17999 may be considered established only when performed to prepare tissues prior to genital surgery in conjunction with procedure codes 55970, 55980, 57291, 57292, or 57335. •Added under Inclusionary and Exclusionary Guidelines/Hormone Therapy: One letter of assessment as indicated below***; and •Removed University of Michigan language under Inclusionary and Exclusionary Guidelines pg 6, under the Exclusions section pg 11, and under Coverage Determination pg 28: •Added the below language under CPT/HCPCS Level II Codes section

			pg 12 and under Inclusionary and Exclusionary Guidelines pg 6. o While the following procedures are considered established for this policy, the specific coverage for each member is based on the benefit, which is defined by the group or employer. •Added *Pre-operative and post-operative care that addresses both surgical results and behavioral health results is highly recommended under Chest surgery, Breast augmentation, Facial surgery, and Genital surgery. •Added the term reconstructive in this medical policy refers to procedures intended to address a significant variation from normal related to disease or treatment of a disease under Gender Affirming Services pg 4. • Replaced statutory with professional and deleted nationally and statutory from nationally accredited statutory institution from: Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field related to transgender health granted by a nationally accredited statutory institution. • Determination to keep blepharoplasty as E/I instead of EST as discussed at JUMP. Removed codes 15820-15823 from EST back to E/I section. Removed blepharoplasty from the list of procedures included in the group of gender affirming facial surgeries (under Inclusions section of the policy under Facial surgery). Returned Blepharoplasty under Exclusions. • Determination to keep codes 21120 and 21125 under EST. •Removed the word lipofilling that was added to MPS under Medically

			necessary gender affirming surgery for adults: • Added codes 15769, 15771, 15772, 15773, and 15774 under E/I section. •Added 21208 to E/I section. Added 21209 to EST section. •Added under Inclusions section after Chest surgery ** and Facial surgery ** **The procedures needed to reconstruct a feminine/masculine appearance can only be performed once per lifetime. • Removed the below from the Genital surgery section on page 10: o The following genital surgeries are considered medically necessary when the above criteria are met: •For male-to-female transgender individuals: o Penectomy o Orchiectomy o Vaginoplasty o Clitoroplasty o Labiaplasty o Vulvoplasty •For female-to-male transgender individuals: o Hysterectomy o Oophorectomy/salpingo-oophorectomy o Urethroplasty o Metoidioplasty o Phalloplasty o Vaginectomy o Scrotoplasty o Implantation of erection and/or Testicular prosthesis References updated (ky

Next Review Date: 4th Qtr, 2023

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: TRANSGENDER SERVICES

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; policy criteria apply. Transgender services are not covered if the contract or certificate language contains specific exclusions of these services.
BCNA (Medicare Advantage)	See Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

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.