



**BlueCross
BlueShield**
Minnesota

Status

Active

Medical and Behavioral Health Policy

Section: Surgery

Policy Number: IV-123

Effective Date: 08/27/2014

Blue Cross and Blue Shield of Minnesota medical policies do not imply that members should not receive specific services based on the recommendation of their provider. These policies govern coverage and not clinical practice. Providers are responsible for medical advice and treatment of patients. Members with specific health care needs should consult an appropriate health care professional.

SURGICAL TREATMENT OF GENDER DYSPHORIA

Description: Gender dysphoria, refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. The therapeutic approach to gender dysphoria, as outlined by the World Professional Association for Transgender Health (WPATH), may consist of several interventions with the type and sequence of interventions differing from person to person. These include psychological and social interventions, continual experience living in the identity-congruent gender role, treatment with hormones and surgery to change the genitalia and other sex characteristics to that of the identity-congruent gender.

Policy:

I. Criteria for All Surgical Treatment

Surgical treatment of gender dysphoria may be considered **MEDICALLY NECESSARY** when **all** of the following criteria have been met. These criteria are based on the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, from the World Professional Association for Transgender Health.

- A. A comprehensive diagnostic evaluation has been completed by a psychiatrist, a clinical psychologist, or other licensed mental health professional who
 1. Is experienced in the evaluation and treatment of gender dysphoria and
 2. Has competence in the diagnosis of gender nonconforming identities and expressions, as well as in diagnosing possible comorbid disorders such as psychotic disorders, personality disorders, and substance related disorders,
 3. Meets the Minnesota Department of Human Services qualifications for a mental health professional, as set forth in Minn.Stat.245.4871, subds.26 and 27 (2011) and Minn.Stat.245.462, subds. 17 and 18 (2011).

Note: If the level of competence of the evaluating or treating mental health professional is uncertain, the health plan will

seek a second opinion from a known expert in the diagnosis and treatment of gender dysphoria.

AND

B. Based on the comprehensive evaluation, the individual meets the diagnostic criteria for gender dysphoria in adolescents and adults per the *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (DSM 5):

1. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration as manifested by **at least two of** the following:
 - a. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
 - b. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
 - c. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - d. A strong desire to be the other gender (or some alternative gender different from one's assigned gender).
 - e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - f. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

AND

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

II. Breast surgery

Breast surgery may be considered **MEDICALLY NECESSARY** when criteria IA and IB and **all** of the following criteria are met:

- A. The member is 18 years of age or older. In female to male (FtM) patients, chest surgery could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatments (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones);
AND
- B. Substantial progress must be demonstrated in the treatment of any comorbid psychopathologies or substance use disorders, resulting in a positive prognosis based on psychological testing, clinical assessment, and clinical judgment prior to planning surgical treatment;
AND
- C. The member has demonstrated the capacity to make a fully

informed decision and consented to treatment;

AND

D. Male to female members have completed a minimum of 12 months of feminizing hormone therapy prior to breast augmentation surgery (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones);

AND

E. Documentation Requirements

1. One letter of recommendation must be provided to a health plan representative from a qualified mental health professional. The letter must address **all** of the following:
 - a. The member's general identifying characteristics; and
 - b. Results of the member's psychosocial assessment, including any diagnoses; and
 - c. The duration of the mental health professional's relationship with the member including the type of evaluation and therapy or counseling to date; and
 - d. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery; and
 - e. A statement about the fact that informed consent has been obtained from the patient; and
 - f. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.
2. The health plan and the physician responsible for breast removal or augmentation must receive this letter and recommendations for surgery and the surgical treatment must be authorized by the health plan prior to its occurrence. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the member's chart.

III. Genital surgery

Genital surgery may be considered **MEDICALLY NECESSARY** when criteria IA and IB and **all** of the following criteria are met:

- A. The member is 18 years of age or older;
- AND**
- B. The member has demonstrated the capacity to make a fully informed decision and consented to treatment;
- AND**
- C. The member has completed 12 continuous months of hormonal therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones);
- AND**
- D. The member has completed 12 continuous months of living full-time in the gender role that is congruent with their gender identity;

AND

E. Substantial progress must be demonstrated in the treatment of any comorbid psychopathologies or substance use disorders, resulting in a positive prognosis based on psychological testing, clinical assessment, and clinical judgment prior to planning surgical treatment;

AND

F. Documentation Requirements

1. Two letters of recommendation from licensed mental health professionals have been obtained; one must be from a licensed doctoral level clinical psychologist or a psychiatrist.
2. Both letters must include all of the information listed in IIE1 a-f.
3. These letters must be presented to the health plan and to the surgeon prior to genital surgery. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the patient's chart.

IV. Other Surgical Procedures

Surgical procedures to alter the gender-specific appearance of a member who has undergone or is planning to undergo gender reassignment surgery, include but are not limited to:

- Facial hair removal
- Blepharoplasty
- Face lift
- Facial bone reconstruction
- Rhinoplasty
- Liposuction
- Reduction thyroid chondroplasty

These procedures are subject to contract definitions for medical necessity or cosmetic surgery benefits, unless otherwise specified in the benefit chart.

Coverage: Treatments for the purpose of sex reassignment are subject to the member's contract benefits. Some contracts have no benefits. In others, benefits are listed in the benefit charts.

Preventive health screening guidelines developed for the general population are appropriate for transgender persons for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. Gender-specific preventive services are also necessary for transgender persons appropriate to their anatomy. Examples include the following.

- Routine Pap smears should be performed as recommended if cervical tissue is present in female-to-male transgender persons.
- If mastectomy is not performed, mammograms should be performed as recommended.

- Male-to-female transgender persons treated with estrogen should follow the same screening guidelines for breast cancer as those for all women.
- Screening for prostate cancer should be performed as recommended for those persons who have retained their prostate.

Blue Cross and Blue Shield of Minnesota medical policies apply generally to all Blue Cross and Blue Plus plans and products. Benefit plans vary in coverage and some plans may not provide coverage for certain services addressed in the medical policies.

Medicaid products and some self-insured plans may have additional policies and prior authorization requirements. Receipt of benefits is subject to all terms and conditions of the member's summary plan description (SPD). As applicable, review the provisions relating to a specific coverage determination, including exclusions and limitations. Blue Cross reserves the right to revise, update and/or add to its medical policies at any time without notice.

For Medicare NCD and/or Medicare LCD, please consult CMS or National Government Services websites.

Refer to the Pre-Certification/Pre-Authorization section of the Medical Behavioral Health Policy Manual for the full list of services, procedures, prescription drugs, and medical devices that require Pre-certification/Pre-Authorization. Note that services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial of claims may result if criteria are not met.

Coding:

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT:

19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
 19303 Mastectomy, simple, complete
 19304 Mastectomy, subcutaneous
 19316 Mastopexy
 19324 Mammoplasty, augmentation; without prosthetic implant
 19325 Mammoplasty, augmentation; with prosthetic implant
 19350 Nipple/areola reconstruction
 54125 Amputation of penis; complete
 54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
 54660 Insertion of testicular prosthesis (separate procedure)

55970 Intersex surgery; male to female
55980 Intersex surgery; female to male
56805 Clitoroplasty for intersex state
57291 Construction of artificial vagina; without graft
57292 Construction of artificial vagina; with graft
57335 Vaginoplasty for intersex state

ICD-9 Procedure:

64.5 Operations for sex transformation, not elsewhere classified

ICD-10 PCS

0W4M070 Creation of Vagina in Male Perineum with Autologous Tissue Substitute, Open Approach
0W4M0J0 Creation of Vagina in Male Perineum with Synthetic Substitute, Open Approach
0W4M0K0 Creation of Vagina in Male Perineum with Nonautologous Tissue Substitute, Open Approach
0W4M0Z0 Creation of Vagina in Male Perineum, Open Approach
0W4N071 Creation of Penis in Female Perineum with Autologous Tissue Substitute, Open Approach
0W4N0J1 Creation of Penis in Female Perineum with Synthetic Substitute, Open Approach
0W4N0K1 Creation of Penis in Female Perineum with Nonautologous Tissue Substitute, Open Approach
0W4N0Z1 Creation of Penis in Female Perineum, Open Approach

Policy History:

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Cross Reference:

Rhinoplasty, IV-73
Liposuction, IV-82
Panniculectomy/Excision of Redundant Skin or Tissue, IV-24

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