MEDICAL POLICY

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MEDICAL POLICY DETAILS	
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Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Based upon our criteria and assessment of the peer-reviewed literature, bilateral mastectomy, with or without chest reconstruction and with or without pectoral implants, including nipple/areola reconstruction and tattooing, for transitioning individuals who were assigned female at birth, has been shown to be a beneficial and effective intervention for gender dysphoria, and, therefore, is considered **medically appropriate** when **ALL** of the following criteria are met:

A. The patient has received a letter of referral from a qualified mental health professional (*refer to Policy Guidelines below*).

B. The patient has been diagnosed with persistent gender dysphoria, including all of the following:

1. The patient has a desire to live and be accepted as a member of the identified gender, usually accompanied by the wish to make their body as congruent as possible with the preferred gender through surgery and hormone treatment;
2. The gender dysphoria has been present persistently for at least one year;
3. The condition is not a symptom of a mental disorder apart from gender dysphoria and
4. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The patient has the capacity to make a fully informed decision and to consent to treatment, as well as the ability to comply with all aftercare instructions, including recommended medical, surgical, nursing, and/or psychological care recommended by the patient's providers.

D. The patient has reached the age of majority (18 years of age or older), or, if under the age of majority, meets all of the following criteria for early intervention:

1. has consent from both parents/guardians for surgery when applicable;
2. has identified as transgender/nonbinary for at least two years;

3. has been receiving testosterone treatment for at least one year, unless hormone therapy is medically contraindicated, or the patient identifies as nonbinary and elects not to pursue hormone therapy;
4. has received an additional letter of referral from a second qualified mental health professional or physician (*refer to Policy Guidelines below*);
5. has compelling reasons impacting their physical and/or psychological well-being, as documented by the patient's mental health/adolescent medicine provider(s); and
6. has reasonably good control over any significant medical or mental health concerns that are present.

Note: Hormone treatment history is not required for *adults* seeking chest reconstruction (including mastectomy) surgery.

II. Based upon our criteria and assessment of the peer-reviewed literature, breast augmentation/implants, including nipple/areola reconstruction and tattooing, for transitioning individuals who were assigned male at birth has been shown to be a beneficial and effective intervention for gender dysphoria, and, therefore, is considered **medically appropriate**, when **ALL** of the following criteria are met:
   A. The patient has received a recommendation letter from a qualified mental health professional (*refer to Policy Guidelines below*).
   B. The patient has been diagnosed with persistent gender dysphoria, including all of the following:
      1. The patient has a desire to live and be accepted as a member of the identified gender, usually accompanied by the wish to make their body as congruent as possible with the preferred gender through surgery and hormone treatment;
      2. The gender dysphoria has been present persistently for at least one year;
      3. The condition is not a symptom of a mental disorder apart from gender dysphoria; and
      4. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
   C. The patient has the capacity to make a fully informed decision and to consent to treatment, as well as the ability to comply with all aftercare instructions, including recommended medical, surgical, nursing, and/or psychological care recommended by the patient's providers.
   D. The patient has reached the age of majority (18 years of age or older).
   E. If significant medical or mental health concerns are present, they are reasonably well-controlled.
   F. The patient has completed a minimum of 24 months of hormone therapy, unless hormone therapy is medically contraindicated, or the patient is otherwise unable to take hormones.

III. Based upon our criteria and assessment of peer-reviewed literature, gonadectomy (i.e., hysterectomy with or without oophorectomy in a birth-assigned female in transition, and orchiectomy in a birth-assigned male in transition) has been shown to be effective and, therefore, is considered **medically appropriate** when **ALL** of the following criteria are met:
   A. The patient has received two recommendation letters submitted by qualified mental health professionals, or has received one letter from a qualified mental health professional and one letter from a physician (MD, DO), as follows:
      1. One letter should be submitted by a mental health professional with whom the individual has had ongoing interactions sufficient to:
         a. establish a diagnosis of persistent gender dysphoria;
         b. rule out other diagnoses that might confound the diagnosis of gender dysphoria;
         c. identify pertinent patient strengths, stressors, and supports; and
         d. diagnose and address other relevant psychological disorders that might interfere with the individual's ability to undergo surgery; and
      2. The second mental health professional or physician providing a recommendation is not required to have an ongoing relationship with the individual but should have significant experience assessing individuals with

gender dysphoria and/or evaluating decision-making capacity in individuals prior to major medical procedures and surgeries (*refer to Policy Guidelines below for additional information*).

B. The patient has an established and well-documented history of gender dysphoria, diagnosed by a mental health professional and present for a minimum of one year, including all of the following:
   1. distress with their assigned gender and with the physical attributes or secondary sex characteristics of their assigned gender;
   2. a desire to change their secondary sex characteristics to better align with their gender identity;
   3. noticeable gender distress that causes clinically significant impairment in social, occupational, or other areas of functioning; and
   4. distress and associated symptoms that are not caused by another psychological disorder

C. The patient has the capacity to make a fully informed decision and to consent to treatment.

D. The patient has reached the age of majority (18 years or older).

E. If significant medical or mental health conditions are present, the patient has appropriate medical and psychiatric providers in place, symptoms are under reasonably good control, and a plan for continued follow-up of these conditions is in place.

F. The patient has a history of 12 months of continuous hormone therapy consistent with the patient's gender goals unless hormone therapy is medically contraindicated.

IV. Based upon our criteria and assessment of the peer-reviewed literature, genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty (including hair removal procedures to treat genital and tissue donor sites), scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in individuals assigned female at birth, in transition; penectomy, vaginoplasty (including hair removal procedures to treat genital and tissue donor sites), labiaplasty, and clitoroplasty in individuals assigned male at birth, in transition) has been medically proven to be effective and, therefore, is considered **medically appropriate** when **ALL** of the following criteria are met:

A. The patient has received two recommendation letters submitted by qualified mental health professionals or has received one letter from a qualified mental health professional and one letter from a physician (MD, DO), as follows:
   1. One letter should be submitted by a mental health professional with whom the individual has had ongoing interactions sufficient to:
      a. establish a diagnosis of persistent gender dysphoria;
      b. rule out other diagnoses that might confound the diagnosis of gender dysphoria;
      c. identify pertinent patient strengths, stressors, and supports; and
      d. diagnose and address relevant psychological disorders that might interfere with the individual's ability to undergo surgery; and
   2. The second mental health professional or physician providing a recommendation is not required to have an ongoing relationship with the individual but should have significant experience assessing individuals with gender dysphoria and/or evaluating decision-making capacity in individuals prior to major medical procedures and surgeries (*refer to Policy Guidelines below for additional information*).

B. The patient has an established and well-documented history of gender dysphoria, diagnosed by a mental health professional, including all the following characteristics:
   1. distress with their assigned gender and with the physical attributes or secondary sex characteristics of their assigned gender;
   2. a desire to change their secondary sex characteristics to better align with their gender identity;
   3. noticeable gender distress that causes clinically significant impairment in social, occupational, or other areas of functioning; and
   4. distress and associated symptoms are not better explained by a psychological disorder apart from gender dysphoria.

C. The patient has the capacity to make a fully informed decision and to consent to treatment (*refer to Policy Guidelines*).
D. The patient has reached the age of majority (age 18 years and older).
E. If significant medical or mental health conditions are present, the patient has appropriate medical and psychiatric providers in place, symptoms are under reasonably good control, and a plan for continued follow-up of these conditions is in place.
F. The patient has a history of 12 months of continuous hormone therapy consistent with the patient's gender goals unless hormone therapy is medically contraindicated.

V. Based upon our assessment of the peer-reviewed literature, feminizing or masculinizing voice therapy and/or voice training services have been medically proven to be effective and, therefore, are considered **medically appropriate** for the treatment of gender dysphoria, when performed by a state-licensed speech-language pathologist or speech therapist. *(Refer to Corporate Medical Policy # 8.01.13 Speech Pathology and Therapy*).

VI. Based upon our assessment of the peer-reviewed literature, voice modification surgery has been medically proven to be effective and, therefore, will be reviewed on a case-by-case basis by a Health Plan medical director with experience in treating patients with mental health conditions, and may be considered **medically appropriate** when **ALL** of the following criteria are met:
A. The patient has received a recommendation letter from a qualified mental health professional (*refer to Policy Guidelines below*).
B. The patient has been diagnosed with persistent gender dysphoria, including all of the following:
1. The patient has a desire to live and be accepted as a member of the identified gender, usually accompanied by the wish to make their body as congruent as possible with the preferred gender through surgery and hormone treatment;
2. The gender dysphoria has been present persistently for at least one year;
3. The condition is not a symptom of a mental disorder apart from gender dysphoria or a chromosomal abnormality; and
4. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The patient has the capacity to make a fully informed decision and to consent to treatment, as well as the ability to comply with all aftercare instructions, including recommended medical, surgical, nursing, and/or psychological care recommended by the individual's providers.
D. The patient has reached the age of majority (18 years of age or older).
E. If significant medical or mental health concerns are present, they are reasonably well-controlled.
F. The patient has completed a minimum of 24 months of masculinizing hormone therapy prior to seeking voice masculinization surgery, unless hormone therapy is medically contraindicated, or the patient is otherwise unable to take hormones.
G. The patient has completed a trial of speech therapy and/or voice training services prior to seeking voice modification surgery.
H. The treatment plan includes post-operative voice training.
I. The treating physician has determined that the requested procedure is medically necessary to treat the patient's gender dysphoria.

VII. Based upon our assessment of the peer-reviewed literature, other surgeries and procedures for the treatment of gender dysphoria, including, but not limited to, facial feminization or masculinization surgery (i.e., blepharoplasty, liposuction of the face or neck, rhinoplasty, facial bone reconstruction, jaw shortening/sculpturing, chin augmentation, cheek augmentation, tracheal shaving/thyroid chondroplasty, hair reconstruction as part of forehead feminization surgery, and electrolysis and/or laser hair removal of face and/or neck (refer to *Policy Guideline IX.*)), liposuction, lipofilling, and gluteal augmentation, will be reviewed on a case-by-case basis by a Health Plan medical

director with experience in treating patients with mental health conditions and may be considered **medically appropriate** when **ALL** of the following criteria are met:

A. The patient has received a recommendation letter from a qualified mental health professional (*refer to Policy Guidelines below*).
B. The patient has been diagnosed with persistent gender dysphoria, including all of the following:
    1. The patient has a desire to live and be accepted as a member of their identified gender, usually accompanied by the wish to make their body as congruent as possible with the preferred gender through surgery and hormone treatment;
    2. The gender dysphoria has been present persistently for at least one year;
    3. The condition is not a symptom of a mental disorder apart from gender dysphoria; and
    4. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The patient has the capacity to make a fully informed decision and to consent to treatment, as well as the ability to comply with all aftercare instructions, including recommended medical, surgical, nursing, and/or psychological care recommended by the individual's providers.
D. The patient has reached the age of majority (18 years of age or older).
E. If significant medical or mental health concerns are present, they are reasonably well controlled.
F. The patient has completed a minimum of 12 months of hormone therapy, unless hormone therapy is medically contraindicated, or the treating provider has determined hormone therapy would have minimal effect due to the patient's age, or the patient identifies as nonbinary and elects not to pursue hormone therapy.
G. The treating team certifies medical necessity of procedures and has adequately addressed co-occurring/co-morbid/additional diagnoses (physical, mental, and behavioral) that may negatively influence outcomes.
H. There is agreement from all physicians and surgeons involved that the patient's physical and psychological status are appropriate to proceed with, and agreement on a common care plan for, the specific procedure.
I. Conservative medical or surgical intervention(s) have been attempted and failed or are contraindicated (e.g., diet and exercise prior to body contouring).

VIII. Based upon our criteria and assessment of the peer-reviewed literature, services to reverse affirming surgery are considered **not medically necessary**, except in the case of a serious medical barrier to completing gender-affirming surgery or the development of a serious medical condition necessitating reversal.

IX. Surgery to revise the appearance or function of previous gender-affirming surgery due to dissatisfaction with the outcome will be reviewed on a case-by-case basis by a Health Plan medical director with experience in treating patients with mental health conditions, when the treating physician has determined that the requested procedure is medically necessary to treat the patient's gender dysphoria. Revision surgery will be considered **medically necessary** when there is significant discomfort, functional impairment, or medical complications resulting from the initial surgery (see Policy Guideline X).

X. Out-of-Network Services

A. Non-urgent Care or Non-emergent Care

Coverage is not provided for services that are not urgent or emergent outside of New York State when services are available in New York State. The Plan contracts with a network of health care practitioners and providers to provide health care services for our members. Care must be received by contracted network providers to be covered by the Plan. Exceptions to this requirement are based on medical necessity and must be approved by a Health Plan Medical Director.

B. Continuation of Care

1. For a member in an ongoing, medically necessary course of treatment with a Participating Provider who leaves the network, coverage is available for continued, ongoing treatment from this now Non-Participating Provider for up to 90 days, or, if a member is in the second or third trimester of pregnancy, for delivery and postpartum care related to the delivery, during which time the provider is considered to

be in-network. If the provider was terminated by the Health Plan due to fraud, imminent harm to patients, or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment by this now Non-Participating Provider will not be covered.

2. For members new to the Health Plan and engaged in an ongoing, medically necessary course of treatment with a Non-Participating Provider, coverage is available for services performed by the Non-Participating Provider for up to 60 days from the effective date of the member's subscriber contract. The ongoing course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. Members are responsible for any in-network cost sharing applicable to these services.

Refer to Corporate Medical Policy #3.01.15 Behavioral Health Treatment for Gender Dysphoria.

Refer to Corporate Medical Policy #4.01.05 Assisted Reproductive Technologies-In Vitro Fertilization.

Refer to Corporate Medical Policy #7.01.55 Blepharoplasty with or without Levator Muscle Advancement.

Refer to Corporate Medical Policy #7.01.11 Cosmetic and Reconstructive Procedures.

Refer to Corporate Medical Policy #7.01.53 Abdominoplasty and Panniculectomy.

Refer to Corporate Medical Policy #8.01.13 Speech Pathology/Therapy for voice therapy requests.

Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery

Refer to Corporate Medical Policy #11.01.26 Medical Services for Transgender Individuals.

This policy does not address coverage of hormone therapies (i.e., gonadotropin-releasing hormone agents/pubertal suppressants and cross-sex hormones). Refer to Pharmacy Management Drug Policy # Pharmacy-63 Clinical Review Prior Authorization (CRPA) Medical for medical necessity requests.

POLICY GUIDELINES

I. Two state-licensed health care professionals must recommend gender-affirming genital surgery. One professional must be a qualified mental health provider with whom the patient has an established and ongoing professional relationship. The recommendation must specify the provider's competency in transgender care. The second professional may be a psychiatrist, psychologist, licensed clinical social worker, or physician. The providers must establish that gender-affirming surgery is medically necessary to treat the patient's gender dysphoria and that the patient demonstrates full capacity for informed decision making, consent, and compliance. Capacity includes: an understanding of common risks and complications, short- and long-term outcomes (e.g., effects on sexual function/fertility), options available to address fertility or sexual function concerns, and the expected benefits associated with surgery. Further, informed decision making requires that an individual have realistic expectations from surgical treatment and have the ability to plan for and comply with the recommendations of their providers with regard to surgical, medical, nursing, and psychological care following surgery. Based on a comprehensive assessment of the patient's capacity, the mental health provider should attest to the patient's readiness and appropriateness for the surgery being proposed. (Note: If breast/chest surgery or surgery/procedures to address secondary sex characteristics is/are the only procedure(s) being requested in an adult patient, only one mental health provider recommendation is required; however, this recommendation must come from a mental health provider with whom the individual has an established and ongoing professional relationship and must include a comprehensive assessment of capacity as outlined above.)

II. An established and ongoing professional relationship is defined as one in which the provider has had ongoing interactions with the patient sufficient to:
   A. establish a diagnosis of severe and persistent gender dysphoria;
   B. rule out other diagnoses that might confound the diagnosis of gender dysphoria;

C. identify pertinent patient strengths, stressors, and supports; and
D. diagnose and address psychological disorders that might otherwise interfere with the patient's ability to undergo surgery.

III. For individuals with considerable comorbidities or a history of severe symptoms (due to gender dysphoria, minority stress, or other mental conditions), the provider may provide a recommendation for surgery that includes an appropriate treatment plan for addressing and mitigating these symptoms, stressors, or conditions in the pre-and post-surgical periods.

IV. The patient should have sufficient medical, nursing, and emotional support to adequately address needs in the post-operative, recovery, and healing period. (For individuals having surgery remotely but returning home less than two weeks following surgery, the patient must have medical providers in place who will be following the surgery both in the home area and/or in the city where surgery is to be performed.)

V. In-home medical/nursing supports are required in the post-operative period, which may include family members, partners, or friends; or, if no family member, partner, or friend is involved, sufficient alternative options for aftercare support (e.g., visiting nurse, etc.) must be identified.

VI. If the patient is to have surgery in an out-of-town location and return home, the medical and/or surgical providers who will be responsible for the patient's post-surgical care and who will manage any complications should be identified. (Note: A plan to use urgent care/emergency care is not sufficient.)

VII. The Health Plan recognizes that treatments and services to address gender dysphoria remain limited. In some areas, especially those areas remote from larger cities, finding surgical and/or mental health providers may be more challenging. For this reason, many individuals elect to have gender affirming treatments and surgeries in remote locations where more comprehensive services and providers with more experience are available. Individuals are encouraged to utilize these centers and facilities for mental health assessments and supports, in addition to surgical treatments. Assessments performed by mental health providers at such facilities will be considered carefully. Further, for individuals experiencing difficulties in locating medical, surgical, or mental health providers for treatment of gender dysphoria and/or for support in pursuing gender-affirming treatment, care management services are available free of charge to members through the Health Plan.

VIII. Hair Removal

A. Laser hair removal, is considered medically appropriate when performed in medical or surgical offices of Health Plan credentialed providers for:

1. Hair removal of the face and/or neck; and
2. Hair removal of genital/tissue donor sites prior to planned gender affirmation surgery.

B. Electrolysis is considered medically appropriate when performed by New York State licensed estheticians or New York State licensed cosmetologists with an active electrologist certification for:
1. Hair removal of the face and/or neck; and
2. Hair removal of genital/tissue donor sites prior to planned gender affirmation surgery.

Documentation should support appropriate certification and education.

Re-evaluation of laser hair removal and/or electrolysis is needed if treatment exceeds 6 months or 30 hours.

IX. Functional impairment requiring revision surgery includes pain or other physical deficit that interferes with activities of daily living or impairs physical activity.

X. Cases requiring a clinical peer review must be made by a Health Plan medical director who specializes in behavioral health and has experience in the delivery of mental health courses of treatment.

DESCRIPTION

The word transgender is an umbrella term that refers to people with a diverse range of gender identities and gender expressions. Gender diversity is normal and transgender people have existed across time and cultures and these individuals are currently referred to as transgender and gender-diverse (TGD) people.

Gender dysphoria, previously known as gender identity disorder (GID), involves a conflict between an individual's gender as perceived (or assigned) and the individual's own internal experience of their gender. The diagnosis of gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), requires that an individual has experienced a discrepancy between their assigned sex at birth and their gender identity, which has been present for at least six months and causes significant impairments in the individual's functioning. Gender dysphoria is not equivalent to gender non-conformity, gender expansiveness, or to the term "transgender." Not all transgender individuals experience gender dysphoria, although many do. Gender dysphoria occurs when the individual feels significant discomfort and a desire to change their gender socially and/or physically. In addition, the individual may feel an intense need to transform their gender and/or may have severe difficulty coping with their conditions. People with gender dysphoria may report a feeling of being born the wrong sex. The causes of gender dysphoria and the developmental factors associated with it are not well-understood. Gender-affirming surgical options to assist an individual to transition to a gender consistent with their identity are now well-established and are effective interventions for the treatment of extreme cases of gender dysphoria for those with sufficient preparation and readiness.

The goal of gender affirming-surgery is to change the body so that it better aligns with an individual's gender identity. Gender affirming surgery effects a permanent change to a patient's anatomy and is not easily reversible. Therefore, a careful and accurate diagnosis is essential for treatment. This process involves an interdisciplinary team, consisting of medical, surgical, and mental health clinicians. The work-up for medical treatments and surgical interventions includes an extensive medical history; gynecological, endocrinological and urological examination, and a clinical psychiatric/psychological examination

Gender dysphoria is a DSM-5-recognized medical condition and a pre-requisite for gender-affirming surgery coverage. Many individuals seek mental health treatment to address gender dysphoria; however, gender-affirming treatment (including surgery) is recognized as effective in treating gender dysphoria. At the same time, gender transition is a stressful experience for most individuals, and this is especially true in the post-operative period. Historically, TGD people have faced, and continue to face, significant discrimination accessing competent and culturally competent medical care in the United States. Barriers to care include minority stress, stigma, lack of access to trained clinicians and institutionalized discrimination. TGD people of color and other subgroups (i.e., related to economic status, rural status, education, ability) face additional barriers to care, resulting in cascading healthcare disparities. These disparities include increased rates of depression, substance abuse, self-harm, suicide, HIV, poverty, and homelessness.

RATIONALE

A diagnosis of gender dysphoria is based on the DSM criteria. The DSM-5 provides for one overarching diagnosis of gender dysphoria, with separate specific criteria for children and for adolescents and adults. In adolescents and adults, gender dysphoria diagnosis involves a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

I. a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics;
II. a strong desire to be rid of one's primary and/or secondary sex characteristics;
III. a strong desire for the primary and/or secondary sex characteristics of another gender;
IV. a strong desire to be of another gender;
V. a strong desire to be treated as another gender; and/or
VI. a strong conviction that one has the typical feelings and reactions of another gender.

Psychological techniques that attempt to treat gender dysphoria via attempts to alter the individual's gender identity or expression to one considered appropriate for the person's assigned sex (conversion treatments) have been shown to be ineffective. Research studies have shown the most effective course of treatment for people with gender dysphoria is gender transition which for many may involve social transition, hormonal therapy, psychotherapy, and gender-affirming surgery. Evidence demonstrates that individuals with untreated gender dysphoria develop higher rates of depression, anxiety, substance use disorders, and suicide.

The literature related to gender affirming surgery has numerous limitations (e.g., lack of controlled studies, evidence not collected prospectively, large number of patients lost to follow-up). However, the majority of patients in case series and cohort studies experienced successful outcomes in terms of subjective self-assessment of their surgery, as well as low rates of regret.

The World Professional Association for Transgender Health or WPATH (formerly known as the Harry Benjamin International Gender Dysphoria Association) Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People are widely accepted as the definitive guidelines for the treatment of gender dysphoria. Per WPATH, the rationale for a preoperative, 12-month experience of living in an identity-congruent gender role is as follows: The criterion noted for some types of genital surgeries—i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity—is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. The social aspects of changing one's gender role may be challenging—for some, this may be more challenging than medical transition. Social transition may have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences).

According to WPATH, the following are minimum credentials for mental health professionals competent in transgender care:

I. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.
II. Competence in using the Diagnostic Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD) for diagnostic purposes.
III. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.
IV. Documented supervised training and competence in psychotherapy or counseling.
V. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
VI. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

The criteria in the SOC are supported by evidence-based, peer-reviewed journal publications. Several studies have shown that extensive long-term trials of hormonal therapy and real-life experience living as the other gender, as well as social support and acceptance by peer and family groups, greatly improve psychological outcomes in patients undergoing gender-affirming surgery (Eldh, 1997; Landen, 1998).

Close collaboration among health professionals involved in the individual's care and treatment is supported in published literature as best practice. A study reported by Monstrey and colleagues (2001) described the importance of close cooperation between the many medical and behavioral specialties required for proper treatment of patients with gender dysphoria who wish to undergo gender-affirming surgery. WPATH states the following regarding the relationship between mental health professional and other health professionals, such as physicians and surgeons: "It is ideal for mental

health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns."

One study of 188 patients undergoing gender-affirming surgery found that dissatisfaction with surgery was highly associated with sexual preference, psychological co-morbidity, and poor pre-operative body image and satisfaction (Smith, 2005). Other researchers (M.I. Lobato et al. (2006), J.C. Goodard et al. (2007)) reported good overall cosmetic results and high patient satisfaction in studies related to the early and long-term follow-up of patients undergoing gender-affirming surgery (n=19 and n=233, respectively).

For many people, gender transition is complicated by negative reactions from families, friends, communities, work sites, schools, and other society institutions. Many individuals who experience gender dysphoria do benefit from psychological support, if only to allow them a safe environment in which to explore their own minority-stress experience, and to process and plan for a transition that is individualized, safe, and affirming for them. In most cases, a stepwise approach to gender affirming transition interventions is prudent. In adults for whom secondary sex characteristics are established, a careful approach to transition and to gender affirming treatment allows for accurate diagnosis and long-term treatment planning by a multidisciplinary team including behavioral, medical and surgical specialists. Both short-term and long-term outcomes are improved in individuals' whose transitions have been well-planned and for whom multidisciplinary services and supports have been put in place. Close collaboration among health professionals involved in the individual's care and treatment is supported in published literature as best practice. A study reported by Monstrey and colleagues (2001) described the importance of close cooperation between the many medical and behavioral specialties required for proper treatment of patients with gender dysphoria who wish to undergo gender reassignment surgery. WPATH states the following regarding the relationship between mental health professional and other health professionals, such as physicians and surgeons: "It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns."

Physical effects of hormone therapy

Per WPATH, feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity. In individuals assigned female at birth, the following physical changes are expected to occur with masculinizing hormone therapy: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass. In patients assigned male at birth, the following physical changes are expected to occur with feminizing hormone therapy: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fat compared to muscle mass. Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable.

Facial feminization/masculinization surgery

Raffani et al. (2016) reported outcomes from a retrospective study of 33 male-to-female patients who underwent facial feminization surgery. Patients were evaluated for quality-of-life outcomes using a nine-question survey at 24 months post-operative. All patient responded positively to the survey. Aesthetic results, assessed objectively by two independent surgeons, were rated "very much improved" (29 of 33 patients, 87.8 percent) or "significantly improved" (four of 33 patients, 12.1 percent).

In a case series of 200 consecutive male-to-female patients in Spain who underwent feminization rhinoplasties, in combination with lip-lift techniques, forehead reconstruction, and other procedures, most patients considered their nose to

appear more feminine after the surgery, and the degree of satisfaction after the rhinoplasty was 4 of 5 points (much better) on the Nose Feminization Scale after a mean follow-up of 32 months (Bellinga et al., 2017).

A prospective, international, multi-center, cohort study (Morrison et al., 2019) of 66 male-to-female patients with gender dysphoria who underwent facial feminization surgery reported quality of life outcomes at least six months following surgery. Pre-operative and post-operative measurements included facial feminization outcome scores using a nine-question, validated tool adapted for use in the transgender population, and self-perceived masculinity and femininity. Gender appearance and general aesthetics were rated by reviewers and compared to cisgender women controls. A total of 279 procedures were performed on 66 patients, for an average of 4.2 procedures per patient. Facial feminization outcome scores improved significantly after surgery (pre-operative median score, 47.2; one-week to one-month post-operative median score, 75.0; and six-month post-operative median score, 80.6). Likewise, patient satisfaction as measured by a five-point Likert scale remained stable post-operatively (median, 3.0 at both one-week to one-month and six months post-operatively). On a scale of 1 to 5, with 1 being most feminine and 5 being most masculine, mean gender appearance score was 1.83 for the facial feminization surgery cohort (n = 10) and 1.25 for a cohort of five cisgender women controls. Aesthetic outcomes on a scale of 1 to 10 were 6.09 for the facial feminization surgery cohort and 7.63 for cisgender controls. Complications included hypertrophic scarring (five patients), orbital emphysema and hematoma (four patients), nasal hematoma and epistaxis (two patients), alopecia (one patient), and iatrogenic jowling or "witches chin" deformity after bony manipulation (two patients).

While data is limited to case series and cohort studies, the evidence supports that patients who undergo rhinoplasty or facial feminization surgery have a meaningful improvement in net health outcome and are generally pleased with the results.

Hair Removal

Hair removal can be critical for individuals seeking to fulfill a desired gender expression, as well as an important task for surgery preparation. Genital reconstructive surgery often utilizes hair-bearing flaps (e.g., forearm, thigh) for reconstruction of the genitals to match an individual's desired gender expression. Hair that is not removed pre-operatively from any skin that will come into contact with urine or be moved to a partially closed cavity within the body can result in post-operative complications, such as urinary retention or obstruction, and infection.

There are multiple techniques for hair removal, but laser hair removal and electrolysis are the most common given their effectiveness, as hormones alone are often insufficient to eliminate unwanted hair. Electrolysis is the only U.S. Food and Drug Administration approved method of permanent hair removal. Laser hair removal is approved for permanent hair reduction only.

Lepster and Elman (2004) discuss the duration of the hair cycle, and state that six to ten laser sessions are required to achieve long term hair reduction given that most laser systems, even at that time, were able to reduce hair from 10-40% in a single treatment, 30-70% with three treatments, and offered a 90% reduction with repeated treatments. The authors additionally concluded that a one-month interval between treatments is sufficient time for the hair to progress to the anagen or growth phase. The anagen phase is when melatonin production occurs and where damage can affect the hair bulge and hair bulb, the structures responsible for hair growth.

A 2022 comparative study of treatment outcomes of electrolysis and laser hair removal for genital hair (Yuan N, et al.) focused on transgender health, demonstrated that a mean number of sessions for permanent genital hair removal was 8.1 with an average frequency of every 5.3 weeks.

New York State does not currently license electrology. Additional certification is required through the American Electrology Association.

Per WPATH, hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process are medically necessary gender- affirming interventions and that hair removal is a very important part of nonbinary gender affirmation (Cochetti, Ristori, Romani et al,. 2020).

Voice therapy

Voice and communication therapy may help to alleviate gender dysphoria. Specialists include speech-language pathologists, speech therapists, and speech-voice clinicians. The average speaking fundamental frequency (SFF) (F0) of adult males is approximately 107–120 Hz, while the average F0 of females is 189–224 Hz (Hancock and Garabedian, 2013). An F0 greater than 160 Hz-180 Hz is often considered the criterion for a transgender woman's voice to be perceived as female (Kim, 2020; Pasternak and Francis, 2019). Shifting pitch upwards is only one variable in female voice perception. Other variables include resonance, breathiness, intonation, voice quality, pragmatics, and non-verbal communication. Feminizing hormone therapy does not have an impact on the adult transfeminine voice.

In a prospective study of five male-to-female transgender (MTF TG) clients, Gelfer and Tice (2013) examined the outcomes from 16 one-hour sessions of voice therapy immediately after the eight-week treatment course and again 15 months later. Outcomes were based on the evaluation of listeners who provided masculine and feminine ratings. Prior to therapy, 1.9% of the subjects were perceived as female, 50.8% of the time in the immediate post-test, and 33.1% of the time in the long-term post-test. The authors concluded that eight weeks of voice therapy could result in vocal changes in MTF TG individuals that persist, at least partially, for up to 15 months.

Voice modification surgery

Surgical techniques for voice feminization include: (1) increasing vocal fold tension through cricothyroid approximation (CTA) or anterior commissure advancement (ACA); (2) shortening the length of the vocal folds through anterior glottal web formation (Wendler glottoplasty); or (3) reducing vocal fold mass through laser-assisted voice adjustment (LAVA) or laser reduction glottoplasty (LRG) (Agana et al., 2019; Kim, 2020). Complications shared among the surgical techniques included dysphonia, reduced maximum phonation time, decreased pitch range, reduced loudness, or the risk of no change in pitch or less than the desired change in pitch (Pasternak and Francis, 2019; Song and Jiang, 2017).

Meister et al. (2017) reported a study of 21 patients in Germany who underwent Wendler's glottoplasty, modified by Hagen, in which the new anterior commissure is stabilized by sutures, and voice rest for several weeks is induced by botox injections into the vocal muscles bilaterally. Four of the patients had previous CTA without satisfaction. The post-operative assessment period ranged from three months to 78 months. Post-procedure, one patient underwent revision surgery and another patient's original anterior commissure persisted, resulting in no elevation of vocal pitch. Comparison of pre- and post- F0 showed elevation in vocal pitch for all other patients. Three patients showed a small elevation of the vocal pitch (less than 20 Hz), four patients showed a moderate elevation (20–39 Hz), five patients showed a strong elevation (40–59 Hz), and eight patients showed a very strong elevation of the fundamental frequency (60 Hz or greater). However, Voice Handicap Index scores showed a persistence of voice handicap and were below control group values. Satisfaction with voice, measured using a 10-cm visual analog scale, resulted in a median of 6.1 cm, and femininity of the voice resulted in a median 5.3 cm. The Life Satisfaction Questionnaire (FLZ) showed a significant reduction in general life satisfaction. The deficiencies in the category "friends, acquaintances, relatives" were significant.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY STATEMENTS AND GUIDELINES CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I).*

CPT Codes

Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc

Code	Description
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat, harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	each additional 25 cc or less injectate, or part thereof (List separately in addition to the code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts (*as part of forehead feminization surgery*)
15776	Punch graft for hair transplant; more than 15 punch grafts (*as part of forehead feminization surgery*)
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	thigh
15833	leg
15834	hip
15835	buttock
15836	arm
15837	forearm or hand
15838	submental fat pad
15839	other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

Code	Description
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
31599	Unlisted procedure, larynx (*can be used for reduction of thyroid cartilage*)
40500	Vermilionectomy (lip shave), with mucosal advancement
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53430	Urethroplasty, reconstruction of female urethra
54120	Amputation penis; partial
54125	Amputation penis, complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

Code	Description
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522	Orchiectomy, partial
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple
55180	Scrotoplasty, complicated
55899	Unlisted procedure, male genital system (*when used to report metoidioplasty/ phalloplasty)
55970	Intersex surgery, male to female
55980	Intersex surgery, female to male
56800	Plastic repair introitus
56805	Clitoroplasty for intersex state
57106	Vaginectomy, partial removal of vaginal wall
57110	Vaginectomy, complete removal of vaginal wall;
58150	Total abdominal hysterectomy, (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152	with colpo-urethrocystopexy (e.g., Marshall-Machetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58263	with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	with repair of enterocele
58275	with total or partial vaginectomy;
58280	with total or partial vaginectomy;
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	for uterus greater than 250 g;
58291	for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	with repair of enterocele

Code	Description
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

ICD10 Codes

Code	Description
F64.0-F64.9	Gender identity disorders (code range)
Z87.890	Personal history of sex reassignment

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*Key Article

KEY WORDS

Gender dysphoria, Gender identity disorder, GID, gender reassignment surgery, genital correction surgery, genital reassignment surgery, genital reconstruction, gender realignment surgery, gender confirmation surgery, intersex, transsexualism, transsexual surgery.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery. Please refer to the following NCD website for Medicare Members. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=368&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=gender+dysphoria&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAACAAAAAA&

A final decision memo was issued in August 2016 by CMS for Gender Dysphoria and Gender Reassignment Surgery. The memo is located at: https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282&CoverageSelection=National&KeyWord=gender+reassignment+surgery&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAACAAAAA%3d%3d&

Per CMS Manual, Pub 100-03, Medicare National Coverage Determinations, Transmittal 194, change request 9981 was issued 03/03/17 with implementation 04/04/2017. Effective for claims with dates of service on or after August 30, 2016, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security 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 transmittal is located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R194NCD.pdf