Gender Reassignment Surgery

Origination: 12/09/14	**Revised:** 4/19/23	**Annual Review:** 12/08/22

Purpose:

To provide gender reassignment surgery guidelines for Population Health and Provider Alliances associates to reference when making benefit determinations.

Additional Information

- Gender reassignment surgery includes multiple procedures and can consist of mastectomy, gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female), and genital reconstruction (**in female-to-male**: vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular and erectile prosthesis; **in male-to-female**: penectomy, vaginoplasty, labiaplasty, and clitoroplasty).

Coverage Guidelines

If a member's plan covers gender reassignment surgery (transgender surgery), the following coverage guidelines will apply.

In addition, certain medications are covered under this benefit and may require prior authorization.

Important Note: Even if not specifically stated in a member's contract, coverage is limited to in-network AvMed participating providers only. Out of network benefits or exceptions do not apply to coverage of gender reassignment surgery.

Gender reassignment surgery may be covered when ALL of the following criteria are met:

- Requests for mastectomy, gonadectomy, or genital reconstruction require ALL of the following:
  1. At least one (1) Referral Letter from a qualified Psychologist or Psychiatrist indicating:
     a. Results of the Member's psychosocial assessment and diagnoses; and
     b. Documentation and results of the type of evaluation and therapy or counseling to date; and
     c. Documentation that the World Professional Association for Transgender Health (WPATH) criteria for surgery have been met and the specific clinical rationale for supporting the Member's request for surgery; and
  2. Documentation of persistent, well-documented Gender Dysphoria (DSM 5 criteria); and
  3. Documentation of Member's capacity to make a fully informed decision and to consent for treatment; and
  4. Member is 18 years of age or older; and
  5. Documentation of at least 12 months of continuous hormone therapy as appropriate to the Member's gender goals (**Note**: that a trial of hormone therapy is not a pre- requisite to qualify for a mastectomy.); and
  6. **Important Note -** For those Members requesting genital reconstruction:
     Two (2) Psychiatric Letters of Referral are needed along with documentation of at least 12 months of living in a gender role that is congruent with their gender identity (real life experience).

Gender Reassignment Surgery

The following procedures could be considered cosmetic but might be a covered benefit, if medically necessary and include, but are not limited to:

- Feminizing procedures including Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction of hyoid (chondroplasty), hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing.
- Masculinizing procedures including chin implants, nose implants, and lip reduction.

The following procedures are not covered:

- Abdominoplasty, brow lift, calf implants, cheek/malar implants, chin/nose implants, collagen injections, liposuction, mastopexy, and pectoral implants.
- Procurement, cryopreservation or storage of embryo, sperm, oocytes for the preservation of fertility and the cryopreservation, storage, and thawing of reproductive tissue (i.e., ovaries, testicular tissue).

References:

1. Current management of male-to-female gender identity disorder in the UK. Postgrad Med J. 2007;83(984):638-642.
2. Evaluation of surgical procedures for sex reassignment: A systematic review. J Plast Reconstr Aesthet Surg. 2009;62(3):294-306; discussion 306-308.
3. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 8 (WPATH).

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.