Clinical Policy Title: Transgender (Gender) Reassignment: Medical and Surgical Treatment of Gender Dysphoria

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ABOUT THIS POLICY: Arbor Health Plan has developed clinical policies to assist with making coverage determinations. Arbor Health Plan clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Arbor Health Plan when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Arbor Health Plan clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Arbor Health Plan clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Arbor Health Plan will update its clinical policies as necessary. Arbor Health Plan clinical policies are not guarantees of payment.

Coverage policy
Arbor Health Plan considers the use of medical and surgical transgender reassignment to be clinically proven and, therefore, medically necessary when the following criteria are met:

I. Criteria:
   A. Member is an adult, age 18 years or older.
   B. Member has the capacity to make fully informed decisions and consent for treatment.
   C. Member has established diagnosis of persistent, well-documented gender dysphoria as defined in the DSM-V-TR criteria of gender dysphoria (GD) in adolescents and adults:
      1. Strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
      2. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by
symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

3. The disturbance is not concurrent with a physical intersex condition.

4. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The diagnosis has been made and documented by a professional who is appropriately trained in transgender medicine. (See glossary for definition of “appropriately trained in transgender medicine.”)

E. Member desires to live and be accepted as a person of the opposite sex, usually accompanied by the wish to make his/her body conform as much as possible with the preferred sex through surgery and hormone treatment.

F. GD has been present persistently for at least two years.

G. GD is not a symptom of another mental disorder.

II. Hormone therapy:

A. Member has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician with documentation of member’s compliance and the type, frequency and route of administration.

Note: Hormonal gender reassignment does not refer to the administration of hormones for the purpose of medical care or research conducted for the treatment or study of non–gender dysphoric medical conditions (i.e., aplastic anemia, impotence, cancer).

III. Real-life experience: documentation that the member has completed a minimum of 12 months of successful continuous full time real-life experience in the new gender:

A. Across a wide range of settings, experiences, and events that occur in the course of normal life (e.g., family events, holidays and vacations).

B. Coming out to partners, family, friends and community members.

C. Medical documentation should include the start date of living full time in the new gender.

D. Confirmation with people who have related to the member in an identity-congruent gender role is recommended.

E. Real-life experience and hormone therapy criteria may occur concurrently.

IV. Psychotherapy:

A. Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or mental health practitioner.

B. If significant medical or mental health issues are present, documentation is required indicating that they are reasonably well controlled.

C. If the member is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), documentation must indicate that an effort has been made to improve these conditions with psychotropic medications and/or psychotherapy before GRS is considered.

V. Referrals:

A. Three referrals are necessary:
   1. One referral must be from the member’s medical provider.
   2. Two referrals must be from qualified mental health professionals who have independently assessed the individual.
3. If the first mental health referral is from the member’s psychotherapist, the second referral should be from an independent evaluator.
4. Two separate letters from the mental health providers, or one signed by both (e.g., if practicing within the same clinic) are required. One letter is sufficient if signed by two providers if one of them has met the doctoral degree specifications (see below).
5. At least one of the mental health professionals submitting a letter must be appropriately trained in transgender medicine. (See glossary).

B. The referral letters must include:

1. Agreement to the proposed GRS within three months of the prior authorization request.
2. Documentation that there are no contraindications to the planned surgery.

C. Format for referral letters/letters of qualification should include:
   • Member’s general identifying characteristics.
   • Results of the member’s psychosocial assessment, including any diagnoses.
   • Duration of the mental health professional’s relationship with the member, including the type of evaluation and therapy or counseling to date.
   • 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.
   • A statement about the fact that informed consent has been obtained from the member.
   • A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

VI. Surgical procedures for transgender reassignment.

A. The following surgeries required for male-to-female are medically necessary if all the criteria listed in sections I. through V. are met:
   1. Genital surgery:
      a. Penectomy.
      b. Orchietomy.
      c. Vaginoplasty.
      d. Clitoroplasty.
      e. Labiaplasty

B. The following surgeries required for female-to-male are medically necessary if all the criteria listed in sections I. through V. are met:
   a. Hysterectomy.
   b. Salpingo-oophorectomy.
   c. Vaginectomy.
   d. Phalloplasty.
   e. Metoidioplasty.
   f. Scrotoplasty.
   g. Urethroplasty.
   h. Testicular prostheses implantation.
   i. Mastectomy.
   j. Reduction mammoplasty.
Limitations: All other uses of medical and surgical transgender reassignment are not medically necessary.

A. Members should be ruled out for surgery if any of the following are applicable:
   1. Active substance abusers within six months of surgery.
   2. Active suicidal ideation or failed suicide attempt one year prior to surgery.
   3. Inpatient psychiatric hospitalization one year prior to surgery.
   4. Positive diagnosis of body dysmorphic disorder, psychotic disorder (e.g., schizophrenia, psychotic disorder not otherwise specified or schizoaffective disorder).

B. Exclusionary criteria — Services should not be covered under the following conditions:
   1. Failure to meet one or more of the criteria for coverage stated in sections I through V in this policy.
   2. Reversal of GRS or any medical procedure covered under original GRS.
   3. Cosmetic procedures used to improve the gender specific appearance of a person who has undergone or is planning to undergo GRS:
      a. Reduction thyroid chondroplasty.
      b. Liposuction.
      c. Rhinoplasty.
      d. Facial bone reconstruction.
      e. Face lift.
      f. Blepharoplasty.
      g. Voice modification surgery.
      h. Hair removal/hairplasty.
      i. Breast augmentation.
      j. Brow lift.
      k. Lip reduction/enhancement.
      l. Chin augmentation.
      m. Facial bone reduction.
      n. Laryngoplasty.
   4. Procedures designed to preserve fertility as part of GRS:
      a. These include but are not limited to the procurement, cryopreservation, thawing or storage of sperm, oocytes, ovaries or testicular tissue.

NOTE: In Nebraska the following codes are not on the Medicaid fee schedule:
- 55970 - Intersex surgery; male to female.
- 55980 - Intersex surgery; female to male.

Alternative covered services-

Background
In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity
(Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female (MTF) or female to male (FTM) as completely as possible (e.g., Green and Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MTF patients to 97% of FTM patients (Green and Fleming, 1990), and regrets were extremely rare (1% – 1.5% of MTF patients and <1% of FTM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting and Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender-nonconforming individuals has come of age — many of whom have benefitted from different therapeutic approaches — they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender-nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves to be either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experiences that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins and King, 2006; Nestle, Wilchins, and Howell, 2002). They may not experience their process of identity affirmation as a “transition,” because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that are comfortable for them.

In 1980 Transsexualism was introduced in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) and 14 years later, in 1994 it was changed to Gender Identity Disorder (DSM-IV-TR). It is supposed to be revised again in 2013 for DSM. Gender identity disorder (previously called transsexualism) is defined as strong and persistent cross-gender identification with the patient’s persistent discomfort with his or her sex and a sense of inappropriateness in the gender role of that sex (Diagnostic and Statistical Manual of Mental Disorders, fourth revision, text revision [DSM-IV-TR]). There is a wide array of terms that have been used to describe people within this group, including MTF, FTM, transwoman, transman, transsexual, gender-affirmed female, gender-affirmed male, and gender-affirmed person.
The disturbance is not concurrent with a physical intersex condition, and causes clinical distress or impairment in social, occupational or other important areas of functioning. The trained mental health professional is obliged to find out if the patient fulfills the criteria of an irreversible gender transposition and if he or she will benefit from medical (hormonal and surgical) sex-reassignment treatment. If a patient has absorbed 12 months of real-life experience and at least 12 months of continuous hormonal treatment, the indication for surgical sex reassignment may be given. Genital sex-reassignment in male-to-female transsexuals includes vaginoplasty, preferably by inversion of penoscrotal skin flaps, clitoroplasty, and vulvoplasty. The operation may be performed in one or two sessions. In contrast to genital reassignment in male-to-female patients, no operative standards are available in female-to-male subjects. Recently, neophallus creation from sensate free forearm flaps has emerged as the most promising approach for those patients who want to have a neophallus. Other alternatives such as metoidioplasty or neophallus reconstruction from regional flaps exist, but are also accompanied by multiple possible complications and re-interventions. Best results are to be expected when using multidisciplinary teams of plastic surgeons, urologists, gynecologists, and experts in sexual medicine in large volume centers. Selvaggi G, et al., (2005) did an overview of gender identity disorder — General overview and surgical treatment for vaginoplasty in male-to-female transsexuals. Gender identity disorder (previously "transsexualism") is the term used for individuals who show strong and persistent cross-gender identification and a persistent discomfort with their anatomical sex, as manifested by a preoccupation with getting rid of one's sex characteristics, or the belief of being born in the wrong sex. Since 1978, the Harry Benjamin International Gender Dysphoria Association (in honor of Dr. Harry Benjamin, one of the first physicians who made many clinicians aware of the potential benefits of sex reassignment surgery) has played a major role in the research and treatment of gender identity disorder, publishing the Standards of Care for Gender Dysphoric Persons. The authors performed an overview of the terminology related to male-to-female gender identity disorder; the different theories regarding cause, epidemiology, and treatment; the goals expected; and the surgical technique available for sex reassignment surgery in male-to-female transsexualism. Surgical techniques available for sex reassignment surgery in male-to-female transsexualism, with advantages and disadvantages offered by each technique, are reviewed. Other feminizing nongenital operative interventions are also examined. Their conclusion was that this review describes recent etiopathogenetic theories and actual guidelines on the treatment of the gender identity disorder in male-to-female transsexuals; the penile-scrotal skin flap technique is considered the state-of-the-art for vaginoplasty in male-to-female transsexuals, whereas other techniques (rectosigmoid flap, local flaps, and isolated skin grafts) should be considered only in secondary cases. As techniques in vaginoplasty become more refined, more emphasis is being placed on aesthetic outcomes by both surgeons and patients.

Natal men and women differ with respect to a number of metabolic variables that are associated with disease. Studies have shown that after the administration of cross-sex hormones, changes may take place with respect to risk factors, such as homocysteine (associated with increased risk of cardiovascular disease and typically higher in natal men), distribution of fat and size of fat cells, insulin sensitivity, and blood pressure (Gooren and Giltay, 2013). Furthermore, cross-sex hormones put individuals at new risk for breast and prostate cancer. Therefore, a number of studies have explored health outcomes related to such risk factors. Some of the studies selected for detailed review reported that intermediate outcomes (risk factors), such as serum lipids and triglycerides, blood pressure, glucose and glycated hemoglobin (HbA1c) levels, liver enzyme levels, measures of renal function, and/or hematological measures were not elevated after hormone therapy when patients were compared either with general population norms or
with transgender patients of the opposite sex (van Kesteren et al., 1997; Dittrich et al., 2005; Cohen-Kettenis et al., 2011; Wierckx et al., 2012; Khatchadourian et al., 2014). The discussion of evidence focus on the actual health outcomes (diagnoses and events) associated with these risk factors plus bone health and obesity.

**Methods**

**Searches:**
Arbor Health Plan searched PubMed and the databases of:
- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality Guideline Clearinghouse and evidence-based practice centers.
- The Centers for Medicare & Medicaid Services.

Searches were conducted on June 27, 2014 using the terms “Gender Identity disorder” and “transsexualism, gender dysphoria” and gender reassignment surgery.

We included:
- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

In evaluating earlier reviews and literature concerning five individual surgical procedures for male-to-female (MTF) transsexism: clitoroplasty, labiaplasty, orchidectomy, penectomy and vaginoplasty. Further evaluations were made of eight surgical procedures for FTM transsexism: hysterectomy, mastectomy, metoidoplasty, phalloplasty, salpingo-oophorectomy, scrotoplasty/placement of testicular prostheses, urethroplasty and vaginectomy. Increased prevalence and advances in surgical options available to patients requesting gender reassignment surgery have made this an important consideration for research. There remains a lack of systematic reviewing of the evidence, in particular, of the individual surgical options available. Searches were undertaken in six electronic databases (Applied Social Sciences Index and Abstracts [ASSIA], Cochrane Library [Wiley Online], Embase [Ovid Online], Medline [Ovid Online], Medline in Process [Ovid Online], Psycinfo) providing coverage of the biomedical, grey literature and current research. Eighty-two published papers (38 MTF; 44 FTM) met the inclusion criteria identified across the 13 surgical procedures. For MTF transsexism there was no evidence satisfying the inclusion criteria concerning labiaplasty, penectomy or orchidectomy procedures. A large amount of evidence was available concerning vaginoplasty and clitoroplasty procedures. For FTM transsexism, satisfactory outcomes were reported. Outcomes related to the ability to perform sexual intercourse, achieve orgasm and void whilst standing. Some complications were reported for both MTF and FTM procedures. In conclusion, the evidence concerning gender reassignment surgery in both MTF and FTM transsexism has several limitations in terms of: (a) lack of controlled studies, (b) evidence has not collected data prospectively, (c) high loss to follow up.
and (d) lack of validated assessment measures. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence.

The prevalence of transsexual people has been determined to be as high as 1 in 11,900 males and 1 in 30,400 females. Standards of care for the psychological, endocrinological, and surgical management of transsexual people have been proposed by the Harry Benjamin International Gender Dysphoria Association Inc. Specific management of hormonal regimens and long-term management, however, remain difficult to navigate. As a result, most physicians depend on observational and anecdotal reports to guide endocrine treatment.

Transgender reassignment surgery is the most important and effective treatment to correct the underlying problem of GID/HBS. The surgeon should be an urologist, gynecologist, plastic surgeon or general surgeon, and board-certified as such by a nationally known and reputable association. The surgeon should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons in this field must be willing to have their therapeutic skills reviewed by their peers. Willingness and cooperation with peer review are essential. This includes attendance at professional meetings where new ideas about techniques are presented.

Follow-up studies have shown undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well-being, cosmesis, and sexual function (De Cuypere et al., 2005: Gifs and Brewaeys, 2007; Klein and Gorzalka, 2009; Pafafflin and Junge, 1998).

Cancer screening:

- Members who have vaginoplasty and mammoplasty surgeries should still have routine mammograms and gynecological exams.
- MTFs will still require periodic prostate screenings even if they have had some form of genital surgery.

Summary of Clinical Evidence

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Lawrence, (2003)</td>
<td>Sex reassignment surgery</td>
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<tr>
<td></td>
<td>• A survey of 232 male-to-female transsexuals at least one-year postoperative (operated on between 1994 and 2000 by one surgeon using a consistent technique) found that patients were happy with their SRS results and that SRS had greatly improved the quality of their lives.</td>
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<tr>
<td></td>
<td>• None reported outright regret, and only a few expressed even occasional regret. Dissatisfaction was most strongly associated with unsatisfactory physical and functional results of surgery.</td>
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<tr>
<td>Lundstrom B</td>
<td>Outcome of sex reassignment surgery:</td>
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<tr>
<td>Source</td>
<td>Description</td>
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<tr>
<td>et al., (1984)</td>
<td>Three independent reviews of the world literature dealing with the outcome of sex reassignment surgery in transsexualism are presented. In 10% – 15% of the patients who undergo sex reassignment the results end up in a failure. There are as many failures in the female-to-male group as in the male-to-female group. Optimal results from the surgical procedures are important for a successful outcome. Relatively high age when first requesting sex reassignment may be regarded as a risk factor for poor outcome. Genuine transsexuals as a group seem to have a better prognosis for successful outcome of sex reassignment than a group of secondary transsexuals (i.e., transvestites and effeminate homosexuals). On the other hand, secondary transsexuals do better than genuine transsexuals when sex reassignment is refused. It is stressed that great importance should be given to the differential diagnosis when evaluating gender dysphoric patients for sex reassignment.</td>
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<td>de Vries et al., (2011).</td>
<td>Effectiveness of pubertal suppression hormone therapy in adolescents. In a pre-test/post-test study of 70 adolescents who underwent approximately two years of pubertal suppression therapy, depression improved slightly, overall emotional disturbance increased slightly, and no change was observed in anger, anxiety, or body image. The authors thought that it was particularly noteworthy that the severity of GD, measured according to the UGDS, remained stable. Thus, the conclusion of the study was that pubertal suppression was a valuable strategy allowing exploration of treatment options for GD. The validity of the findings is somewhat questionable, since baseline measurements were made on average one year before pubertal suppression began and the participants aged by approximately three years from baseline measurement to follow-up measurement. The independent effects of mental and emotional maturation and the pubertal suppression therapy are unknown. The differences in improvement between biological males and females were small and generally nonsignificant, but the analysis did not adjust for the approximately one-year age difference between the two sexes. Evidence from this single small study is insufficient to support conclusions regarding pubertal suppression therapy.</td>
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<tr>
<td>Hayes (2013)</td>
<td>Comparative effectiveness of hormone therapy alone vs. surgery (adults). The case series by Wierckx et al. (2014) (n = 352) found that sexual desire was higher in those patients who had undergone SRS in addition to hormone therapy.</td>
</tr>
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</table>
• A smaller (n = 50) pre-test/post-test study found almost no change in sexual activity before and after SRS, whereas some improvements had been observed over the course of the preceding course of hormone therapy (Costantino et al., 2013).

• Another study (n = 187; 120 in hormone therapy group) compared anxiety and depression scores between those who had and had not undergone SRS within the hormone therapy group; differences slightly favored SRS on one scale but showed no difference on two scales, whereas differences between the hormone therapy group and untreated individuals suggested consistently significant (statistically) although modest differences (Gómez-Gil et al., 2012).

• The pre-test/post-test study by Heylens et al. (2014) (n = 57) observed a very small and nonsignificant worsening of psychological distress from a point in time three to six months after initiation of hormone therapy to assessment at one to 12 months after SRS.

• Because of conflicting results across different outcome measures and the small quantity of data for each outcome, no conclusions regarding the comparative benefits of SRS and hormone therapy alone may be made.

Glossary

**Appropriately trained professional working with adults who present with gender dysphoria** — The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A Master’s degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Disease* for diagnostic purposes.
3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.
5. 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.

**Note:** In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred. Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria (The WPATH SOC-7, 2012).

**FTM** — A person who transitions from “female-to-male,” meaning a person who was assigned female at birth, but identifies and lives as a male.

**Gender identity** — The sense of being male or female that is usually in accord with, but sometimes opposed to, physical anatomy.

**Gender dysphoria** — A condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in the person’s own gender (Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition [DSM-V, 2013]).

**Gender identity disorder** — A strong and persistent cross-gender identification (not concurrent with a physical intersex condition or simply a desire for any perceived cultural advantages of the other sex), marked by persistent discomfort with one’s sex, or a sense of inappropriateness in the gender role of that sex, and causing clinically significant distress or impairment in social, occupational or other important areas of functioning.

**Gender reassignment surgery (GRS)** — A treatment option for extreme cases of GD. GRS is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the member to achieve successful behavioral and medical outcomes. Used interchangeably with sexual reassignment surgery.

**Genital surgical gender reassignment** — Genital surgery that alters the morphology to approximate the physical appearance of the genetically other sex. The following surgical procedures (occurring in the absence of any diagnosable birth defect or other medically defined pathology [except gender dysphoria]) are included in this category:

1. **Hysterectomy** — removal of uterus.
2. **Labiaplasty** — creation of labia.
3. **Mastectomy** — removal the breast.
4. **Mentoplasty** — creation of micro-penis, using the clitoris, inadequate for sexual penetration but sometimes allowing voiding while standing.
5. **Oophorectomy** — removal of ovaries.
7. **Penectomy** — removal of penis.
8. **Phalloplasty** — creation of penis, with or without urethra.
11. Scrotoplasty — creation of scrotum.
12. Testicular prostheses — implantation of artificial testes.
13. Urethroplasty — creation of urethra with the penis.
15. Vaginoplasty — creation of vagina.

**Harry Benjamin Syndrome (HBS)** — A medical condition caused by a biological variation in human sexual formation — an intersex condition — where the sex indicated by the phenotype and the genotype is opposite the morphological sex of the brain. Harry Benjamin Syndrome is named in honor of Dr. Harry Benjamin, a pioneer in the research of this condition. He was the physician who contributed much to the understanding and recognition of this condition. It was through his efforts the entire medical community came to understand HBS was unrelated to homosexuality.

**Hormonal gender reassignment** — The administration of androgens to genotypic and phenotypic females and estrogen or progesterone to genotypic or phenotypic males for the purpose of effecting somatic changes to more closely approximate the physical appearance of the genotypically other sex.

**Intersex** — A term used for people who are born with a reproductive or sexual anatomy and/or chromosome pattern that does not seem to fit typical definitions of male or female. Intersex conditions are also known as differences of sex development (DSD). These conditions can involve abnormalities of the external genital, internal reproductive organs, sex chromosomes, or sex-related hormones.

**MTF** — A person who transitions from “male-to-female”, meaning a person who was assigned male at birth, but identifies and lives as a female. Also known as a “transgender woman.”

**Nongenital surgical gender reassignment** — Any other surgical procedures involving nongenital sites (e.g., breasts, skin, nose, throat, chin, cheeks, hips or waist) that may be performed to effect a more masculine appearance in a genetic female or a more feminine appearance in a genetic male.

**Sexual Orientation** — A term describing a person’s attraction to members of the same sex and/or a different sex, usually defined as lesbian, gay, bisexual, heterosexual, or asexual.

**Primary sex characteristics** — Refers to the genetically determined sex characteristics related to reproduction. The primary sex characteristics are the genital organs and their related hormones.

**Real-life experience (RLE)** — The act of fully adopting a new or evolving gender role or gender presentation in everyday life”, with the intention of achieving an experiential understanding of the familial, interpersonal, socioeconomic, and legal consequences of gender transition (Hembree et al., 2009; Meyer et al., 2001).

**Secondary sex characteristics** — Refer to various genetically transmitted physical or behavioral characteristics that appear in humans at puberty and differentiate between the sexes without having a direct reproductive function.
Transgender real-life experience — Undertaken to assess the ability and resolve of persons undergoing gender reassignment to fully adapt to and successfully function in their new or evolving gender role or presentation. The transgender real-life experience allows persons with GID and their clinicians to determine whether or how to proceed with further treatment.

Transmen — Female-to-male.

Transsexuals — Individuals who have had or wish to have gender reassignment surgery (GRS), or who receive hormone therapy but do not wish to have GRS (nonoperative transsexuals), and live full-time in their new gender role.

Transsexualism — Also known as gender identity disorder.

Transwomen — Male-to-female.

Transsexual surgery, also known as sex reassignment surgery or intersex surgery — The culmination of a series of procedures designed to change the anatomy of transsexuals to conform to their gender identity. Transsexuals are persons with an overwhelming desire to change anatomic sex because of their fixed conviction that they are members of the opposite sex. For the male-to-female, transsexual surgery entails castration, penectomy and vulva-vaginal construction. Surgery for the female-to-male transsexual consists of bilateral mammectomy, hysterectomy and salpingo-oophorectomy which may be followed by phalloplasty and the insertion of testicular prostheses.

Related policies: Arbor Health Plan Utilization Management program description.

References

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Definitions of Medical Terms and Diagnostic Criteria for Gender Identity Disorder. Vancouver: The Zenith Foundation; 2003.


Specialty-matched clinical peer review.

The Endocrine Society issued Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, September 2009 (Hembree et al., 2009).


World Professional Association for Transgender Health (WPATH), Standard of Care (SOC) version 7 2012.

Peer-reviewed references:


Clinical Trials:


Centers for Medicare and Medicaid Services (CMS) National Coverage Determination (NCD)
NCD for Transsexual Surgery (140.3), publication number-13-3, Effective date of this version is longstanding national coverage determination and has not been published.

Local Coverage Determinations (LCD)

As of this writing no LCD was found for this topic.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals, and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>19325</td>
<td>Mammaplasty, augmentation; with prosthetic implant.</td>
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</tr>
<tr>
<td>19340</td>
<td>Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.</td>
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</tr>
<tr>
<td>19342</td>
<td>Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.</td>
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</tr>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction.</td>
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</tr>
<tr>
<td>31750</td>
<td>Tracheoplasty; cervical.</td>
<td></td>
</tr>
<tr>
<td>53430</td>
<td>Urethroplasty, reconstruction of female urethra.</td>
<td></td>
</tr>
<tr>
<td>54125</td>
<td>Amputation of penis; complete.</td>
<td></td>
</tr>
<tr>
<td>54520</td>
<td>Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach.</td>
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</tr>
<tr>
<td>54660</td>
<td>Insertion of testicular prosthesis (separate procedure).</td>
<td></td>
</tr>
<tr>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy.</td>
<td></td>
</tr>
<tr>
<td>55150</td>
<td>Resection of scrotum.</td>
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</tr>
<tr>
<td>55175</td>
<td>Scrotoplasty; simple.</td>
<td></td>
</tr>
<tr>
<td>55180</td>
<td>Scrotoplasty; complicated.</td>
<td></td>
</tr>
<tr>
<td>55970</td>
<td>Intersex surgery; male to female.</td>
<td></td>
</tr>
<tr>
<td>55980</td>
<td>Intersex surgery; female to male.</td>
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</tr>
<tr>
<td>56620</td>
<td>Vulvectomy simple; partial.</td>
<td></td>
</tr>
<tr>
<td>56625</td>
<td>Vulvectomy simple; complete.</td>
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</tr>
<tr>
<td>56800</td>
<td>Plastic repair of introitus.</td>
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<tr>
<td>56805</td>
<td>Clitoroplasty for intersex state.</td>
<td></td>
</tr>
<tr>
<td>57106</td>
<td>Vaginectomy, partial removal of vaginal wall.</td>
<td></td>
</tr>
<tr>
<td>57107</td>
<td>Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy).</td>
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</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>57110</td>
<td>Vaginectomy, complete removal of vaginal wall.</td>
<td></td>
</tr>
<tr>
<td>57111</td>
<td>Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy).</td>
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</tr>
<tr>
<td>57291</td>
<td>Construction of artificial vagina; without graft.</td>
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</tr>
<tr>
<td>57292</td>
<td>Construction of artificial vagina; with graft.</td>
<td></td>
</tr>
<tr>
<td>57335</td>
<td>Vaginoplasty for intersex state.</td>
<td></td>
</tr>
<tr>
<td>57530</td>
<td>Trachelectomy (cervicectomy), amputation of cervix (separate procedure).</td>
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</tr>
<tr>
<td>58150</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s).</td>
<td></td>
</tr>
<tr>
<td>58180</td>
<td>Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s).</td>
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</tr>
<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250 g or less.</td>
<td></td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s).</td>
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</tr>
<tr>
<td>58263</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele.</td>
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</tr>
<tr>
<td>58270</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele.</td>
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<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy.</td>
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<tr>
<td>58280</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele.</td>
<td></td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g.</td>
<td></td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).</td>
<td></td>
</tr>
<tr>
<td>58292</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele.</td>
<td></td>
</tr>
<tr>
<td>58294</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele.</td>
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</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less.</td>
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</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).</td>
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</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g.</td>
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</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).</td>
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</tr>
<tr>
<td>58550</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less.</td>
<td></td>
</tr>
<tr>
<td>58552</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).</td>
<td></td>
</tr>
<tr>
<td>58553</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g.</td>
<td></td>
</tr>
<tr>
<td>58554</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).</td>
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</tr>
<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less.</td>
<td></td>
</tr>
<tr>
<td>ICD-9 Code</td>
<td>Description</td>
<td>Comment</td>
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<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>302.50</td>
<td>Trans-sexualism with unspecified sexual history.</td>
<td>Sex reassignment surgery status</td>
</tr>
<tr>
<td>302.51</td>
<td>Trans-sexualism with asexual history.</td>
<td>Sex reassignment surgery status</td>
</tr>
<tr>
<td>302.53</td>
<td>Trans-sexualism with homosexual history.</td>
<td>Sex reassignment surgery status</td>
</tr>
<tr>
<td>302.85</td>
<td>Gender identity disorder in adolescents or adults.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
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