Policy Number	**SUR717.001**
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Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

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Related Policies (if applicable)
None

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

NOTE: State Legislation may apply. Carefully check for legislative mandates that may apply for each plan.

EXCEPTION: For Texas members only: Effective September 1, 2025, TIC Chapter 1373 (§§1373.001 – 1373.003) (SB 1257) requires coverage for the following: A health benefit plan that provides or has ever provided coverage for an enrollee's gender transition procedure or treatment shall provide coverage for, including for any applicable diagnostic or billing code: (1) all possible adverse consequences related to the enrollee's gender transition procedure or treatment, including any short- or long-term side effects of the procedure or treatment; (2) any baseline and follow-up testing or screening necessary to monitor the mental and physical health of the enrollee on at least an annual basis without regard to the sex or gender identity designation in the enrollee's medical record; and(3) any procedure, treatment, or therapy necessary to manage, reverse, reconstruct from, or recover from the enrollee's gender transition procedure or treatment. (b) A health benefit plan that offers coverage for a gender transition procedure or treatment shall also provide the coverage described by Subsection (a) to any enrollee who has undergone a gender transition procedure or treatment regardless of whether the enrollee was

enrolled in the plan at the time of the procedure or treatment. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS, ERS, TRS, UT/TAMU, Medicaid/CHIP, PEO; group health coverage provided to a Texas resident regardless of whether the group contract was issued in Texas.

EXCEPTION: Montana only: Effective October 1, 2026, HB 682 requires a group or individual insurance policy that covers gender transition treatment must also include coverage for detransition treatment under the same cost sharing policies. If the group or individual insurance policy ceases coverage for gender transition treatment, the policy is not required to provide equivalent coverage for detransition treatment, except that the policy must provide equivalent coverage to insureds who were enrolled when gender transition treatment coverage was provided and received benefits under that coverage. This applies to Individual, Family, Group, Fully Insured, Non-ERISA ASO, PPO, HMO, POS, State of Montana Health Plan, and Healthy Montana Kids.

ILLINOIS Legislative Mandate: 50 Illinois. Administrative. Code 2603.35 provides that a group health insurance plan that is neither a grandfathered plan nor a plan offering excepted benefits shall not discriminate on the basis of an insured's or prospective insured's actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person.

Pursuant to the above, Gender Reassignment Surgery would be a covered benefit for Illinois insured policies subject to the coverage criteria set forth below.

Coverage

CAREFULLY REVIEW the member's benefit contract for gender reassignment surgery and related services provisions. If there is a discrepancy between this medical policy and the member's benefit contract, the contract will govern.

I. GENDER ASSIGNMENT SURGERY

Gender assignment surgery for individuals with ambiguous genitalia diagnosed at birth or in infancy is considered reconstructive surgery and **may be considered medically necessary.**

II. GENDER REASSIGNMENT SURGERY

Gender reassignment surgery -- also known as transsexual surgery or sex reassignment surgery -- and related services **may be considered medically necessary** when meeting the criteria for gender dysphoria listed below.

Otherwise, gender reassignment surgery and related services **are considered not medically necessary**.

A. Gender Reassignment Surgery and Related Services for Adolescents:

The following services **may be considered medically necessary** for the treatment of gender dysphoria for adolescents:

- Hormone therapy (such as, puberty-suppressing hormones or masculinizing/feminizing hormones);

- Psychological services, including but not limited to psychotherapy, social therapy, and family counseling; and/or
- Chest surgery for female-to-male (FtM) individuals.

The individual being considered for surgery and related services meets ALL the following criteria. The individual must have:

- Met the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care; and
- The experience of gender diversity/incongruence is marked and sustained over time; and
- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; and
- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; and
- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development; and
- The adolescent has reached tanner stage 2 of puberty for pubertal suppression to be initiated; and
- The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated; and
- The required referrals prior to any surgery or related service(s):
    - Prior to feminizing or masculinizing hormonal therapy, one required referral from the individual's qualified mental health professional (**see NOTE 1**) competent in the assessment and treatment of gender dysphoria; and/or
    - Prior to breast/chest surgery, e.g., reduction/reconstruction/augmentation, one required referral from the individual's qualified mental health professional (**see NOTE 1**) competent in the assessment and treatment of gender dysphoria.

B. Criteria for Coverage of Gender Reassignment Surgery and Related Services for Adults:

The individual being considered for surgery and related services must meet ALL the following criteria. The individual must have:

- The capacity to make a fully informed decision and to consent for treatment; and
- Been diagnosed with persistent, well-documented gender dysphoria; and
- The required referrals prior to any surgery or related service(s):
    - Prior to feminizing or masculinizing hormonal therapy, one required referral from the individual's qualified mental health professional (**see NOTE 1**) competent in the assessment and treatment of gender dysphoria; and/or
    - Prior to breast/chest surgery, e.g., reduction/reconstruction/augmentation, one required referral from the individual's qualified mental health professional (**see NOTE 1**) competent in the assessment and treatment of gender dysphoria; and/or

- Prior to any genital surgery, e.g., hysterectomy, salpingo-oophorectomy, orchiectomy, and/or other genital reconstructive procedures, two separate required independent referrals (or one signed by both referring providers) from the individual's qualified mental health professionals (**see NOTE 1**) competent in the assessment, treatment of gender dysphoria, and addressing the identical/same surgery to be performed.

NOTE 1: Psychotherapy and Mental Health Services: Psychotherapy is not required for gender reassignment services except when a mental health professional recommends psychotherapy based on initial assessment prior to gender reassignment surgery. The recommendation for psychotherapy must specify the goals of treatment along with estimates of the frequency and duration of therapy throughout the individual's experience living in one's affirmed gender.

NOTE 2: Health care professionals may consider gender-affirming genital procedures for eligible transgender and gender diverse adults seeking these interventions when there is evidence that the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

For individuals undergoing gonadectomy who are not taking hormones, a plan for hormone replacement can be developed with their prescribing professional prior to surgery.

C. Gender Reassignment Pharmaceutical Services:
Continuous hormone replacement therapy **may be considered medically necessary** prior to or following gender reassignment of either male-to-female (MtF) or FtM surgical services.

Continuous hormone replacement therapy may include the following services:
- Hormone injections by the medical provider, such as during an office visit; and/or
- Self-administered oral and injectables obtained from a pharmacy; and/or
- Implantable testosterone pellets (once appropriate dosing is stabilized).

Pharmaceutical agents to treat hair loss or growth, sexual performance post-gender reassignment genital surgery (e.g., Viagra or Cialis), and/or cosmetic enhancements, including collagen and/or botulinum toxin injections, **are considered not medically necessary.**

D. Gender Reassignment Laboratory Services:
Laboratory testing to monitor continuous hormonal replacement therapy for treatment of gender dysphoria **may be considered medically necessary**.

E. Primary Sexual Characteristic Gender Reassignment Chest and/or Genital Surgeries:
MtF surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:
- Breast modification, including but not limited to breast enlargement, breast augmentation, mastopexy, implant insertion, silicone injections, and nipple or areola reconstruction;

- Clitoroplasty;
- Coloproctostomy;
- Colovaginoplasty;
- Labioplasty;yp
- Orchiectomy;
- Penectomy;
- Penile skin inversion;
- Repair of introitus;
- Vaginoplasty with construction of vagina with graft; and/or
- Vulvoplasty.

Female-to-Male (FtM) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

- Hysterectomy;
- Metoidioplasty;
- Phalloplasty;
- Placement of an implantable erectile prostheses;
- Placement of testicular prostheses;
- Salpingo-oophorectomy;
- Scrotoplasty;
- Subcutaneous mastectomy, including nipple or areola reconstruction;
- Vaginectomy (colpectomy);
- Urethroplasty; and/or
- Urethromeatoplasty.

F. <u>Secondary</u> Sexual Characteristic (Masculinizing or Feminizing) Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan **may be considered medically necessary for the treatment of gender dysphoria ONLY.** These procedures may include, but are not limited to the following:

- Abdominoplasty;
- Blepharoplasty;
- Brow lift;
- Calf implants;
- Cheek implants;
- Chin or nose implants;
- External penile prosthesis (vacuum erection devices);
- Face lift (rhytidectomy);
- Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
- Forehead lift or contouring;

- Hair removal (laser hair removal or electrolysis) which may include donor skin sites; or hair transplantation (hairplasty);
- Laryngoplasty;
- Lip reduction or lip enhancement;
- Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;
- Neck tightening;
- Pectoral implants;
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
- Redundant/excessive skin removal;
- Rhinoplasty (nose correction);
- Skin resurfacing;
- Testicular expanders;
- Voice modification surgery; and/or
- Voice (speech) therapy or voice lessons.

NOTE 3: Preparatory or ancillary procedures (such as anesthesia, tissue harvesting for skin, fat, nerve or muscle grafting, etc.) and supplies or equipment (such as stents, prosthesis, implants, etc.) that are required for the procedures listed above are considered an integral part of the MtF or FtM transition process.

NOTE 4: Surgical repairs or revisions related to MtF or FtM procedures may be required, such as removal and replacement of prostheses.

G. Gender Primary or Secondary Sexual Characteristic Revision Surgeries

When there is documented evidence of physical functional impairment, gender primary or secondary sexual characteristic revision procedures or services **may be considered medically necessary**.

When there is **no** documented evidence of physical functional impairment, gender primary or secondary sexual characteristics revision services **are considered not medically necessary** (refer to appropriate procedure-specific policy).

H. Gender Reassignment Reproductive Services:

Procurement, cryopreservation/freezing, storage/banking, and thawing of reproductive tissues, such as oocytes, ovaries, embryos, spermatozoa, and testicular tissue **may be considered medically necessary** for individuals with gender dysphoria because gender reassignment services, such as long-term cross-sex hormone therapy or surgical procedures, may render an individual infertile whether or not the individual has reproduced in the past.

I. Reversal of Gender Reassignment Surgical Procedures

For reversal of any of the prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics, the individual must meet the same criteria for gender dysphoria to have those reversal procedures **considered medically necessary**.

If the criteria for gender dysphoria is not met, then reversal of any prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics **is considered not medically necessary.**

J. Preventive Medicine Gender Reassignment Services:
Preventive medicine services that **may be considered medically necessary** in conjunction with gender reassignment services include:

- Breast cancer screening for FtM individuals; or
- Cervical cancer screening for FtM individuals; or
- Prostate cancer screening for MtF individuals; or
- Contraception pharmaceuticals for FtM individuals at risk of pregnancy.

Policy Guidelines

The CPT code for mastectomy (19303) is for breast cancer/cancer prevention and should not be used to bill for reduction mammaplasty for female to male (transmasculine) gender affirmation surgery. A more appropriate code to report this service is 19318, as it includes the work that is necessary to create a more aesthetically pleasing result.

Refer to Coding section for information on CPT codes to report female-to-male breast/chest surgery.

Description

Gender Assignment Surgery
Disorders of Sexual Development
Disorders of sexual development (DSD) is defined as congenital conditions in which the development of chromosomal, gonadal and anatomical sex is atypical. (1) These conditions can be identified at different times of life, in fetuses or newborns with ambiguous external genitalia, gonadal dysgenesis and internal genitalia that are discordant for the constitution of sexual chromosomes, also can be subsequently diagnosed in individuals with late puberty, unexpected virilization or gynecomastia, infertility or gonadal tumors. (2)

To the lay person, the determination of an infant's sex can easily be identified as male or female, by virtue of outward genital anatomy, secondary sexual characteristics and behavior within their relevant cultural context. Arriving at a satisfactory scientific definition is more difficult as gender reflects the outcome of complex interactions occurring from the time of conception and extending throughout pre- and post-natal life. (3)

Intersex anomalies associated with ambiguous genitalia may result from major chromosomal abnormalities or from specific gene mutations as in congenital adrenal hyperplasia. (3) The phenotypic manifestation of DSDs is diverse and can vary from those that appear typically female to those that appear typically male. Other manifestations can include bilateral undescended testes, severe hypospadias (scrotal or perineal), clitoromegaly, a fusion of posterior labial folds, female external genitalia with palpable gonad, discordant genitalia, and sex chromosomes. (1)

The incidence of a child with a DSD is approximately 1 in 1000 to 4500 live births. (1) The most frequently occurring etiology was congenital adrenal hyperplasia (CAH) followed by androgen insensitivity and mixed gonadal dysgenesis. Congenital adrenal hyperplasia can be divided into 2 types—classic and non-classic—depending on the severity of the variant and the degree of enzyme function loss. (4) Classic (severe) CAH may present as simple virilizing CAH or salt-wasting CAH, typically diagnosed in infancy. In contrast, patients with non-classic CAH, which presents with milder symptoms, may be asymptomatic, show mild virilization postnatally, or lead to features of polycystic ovary syndrome (PCOS) and infertility in adolescents and adult females.

Regardless of presentation or severity, individuals require an interprofessional approach that is warranted to improve the quality of life and achieve the best possible outcomes. (1) The overall health of the child should be assessed, and parents should be educated about typical sexual development before explanations regarding the underlying cause and its implications for their child's ambiguous genitalia are provided. Even if the exact details of the underlying cause remain unresolved, it is essential to communicate what is known and what remains uncertain to the parents and make plans for the family's future in the best interests of the child. (5)

Regulatory Status

Gender assignment surgical procedures are surgical interventions and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

Gender Reassignment Surgery

Gender dysphoria (formerly known as ‘gender identity disorder’) is a condition recognized by the Diagnostic and Statistical Manual (DSM) of Mental Disorders and commonly known as transsexualism. (6) The diagnostic criteria describe many individuals who experience dissonance between their sex at birth and personal gender identity, which is not the same as having ambiguous genitalia. According to a report from the University of California Los Angeles (UCLA) Williams Institute School of Law, based on population surveys completed in 2016-2017 of 43 states, it suggested that the number of adults who identify as “gender non-conforming” or transgender is 0.6% (1.6 million). (7) On the basis of that data, it is estimated that 1.4% of youth, ages 13 to 17 years (~300,000) identify as transgender.

Gender reassignment surgery (GRS) is also known as sex reassignment surgery; genital reconstruction surgery; sex affirmation surgery; sex realignment surgery; intersex surgery, or sex-change operation. It is a term used for the culmination of a series of surgical procedures

and treatments by which a person's physical appearance and the function(s) of existing sexual characteristics are altered or even irreversibly changed to that of the opposite sex. Gender reassignment generally consists of several treatment plans, which include the diagnostic phase (mostly supported through mental health professional interaction) followed by continuous hormonal therapy (through an endocrinologist). It includes living openly in a manner consistent with the affirmed gender or completed with the GRS itself. (6)

Other terms are used to describe these procedures. These include sex reconstruction surgery; gender confirmation surgery; feminizing genitoplasty or penectomy, orchidectomy and vaginoplasty for trans women, with masculinizing genitoplasty or phalloplasty for trans men. (Definitions of these procedures can be found later in this Description section.) These procedures and services are used to treat individuals diagnosed with gender dysphoria in transsexual or transgender individuals. (2, 3)

Guidelines for GRS and related services were first developed by the World Professional Association for Transgender Health (WPATH) in 1979. (8) WPATH is an international, multispecialty, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. In September 2022, WPATH stated that developments involving a depathologization (or more precisely a de-psychopathologization) of transgender identities, are fundamentally important. In the field of health care, they may have helped support a care model that emphasizes patients' active participation in decision-making about their own health care, supported by primary health care professionals. It is reasonable to suppose these developments may also promote more socially inclusive policies such as legislative reform regarding gender recognition that facilitates a rights-based approach, without imposing requirements for diagnosis, hormone therapy and/or surgery. "The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon that should not be seen as inherently negative or pathological." WPATH clarified the related procedures and services when an individual is considering surgical transformation from male-to-female (MtF) or female-to-male (FtM), as well as how the treatment differs for gender dysphoria and transsexualism.

<u>WPATH Standards of Care (SOC)</u>
The WPATH SOC document provides an overview of surgical procedures to treat patients with gender dysphoria, otherwise known as gender affirming surgeries. (6, 8)

"For the MtF (male-to-female) patient, surgical procedures <u>may include</u> the following:
1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures."

"For the FtM (female-to-male) patient, surgical procedures <u>may include</u> the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of male chest;
2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicle or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;
3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures."

SOC criteria for surgical services were introduced as a guide to decision making for breast/chest and genital surgery. (8) However, the SOC does not include criteria for other surgical procedures, such as masculinizing or feminizing facial surgery. The SOC does not stipulate the number, sequence, and/or timing of surgical procedures because they will vary from patient to patient, according to an individual patient's clinical needs and expectations, in collaboration with mental health and surgical professionals.

Definitions of Irreversible Chest and Genital Surgical Procedures for Gender Reassignment

- Augmentation mammaplasty – insertion of breast implants or lipofilling (suctioning of body fat from one body area and filling into another body area) to create the female chest.
- Clitoroplasty – creation of a clitoris, utilizing the penile glans.
- Genitoplasty – genital reconstruction or modification of genitalia.
- Hysterectomy/salpingo-oophorectomy – removal of the uterus with or without ovaries and fallopian tubes.
- Metoidioplasty – following testosterone replacement therapy, the clitoris enlarges to be separated from the labia minora to create a penis.
- Orchiectomy – both testicles are removed.
- Penectomy – removal of the penis.
- Phalloplasty – construction or reconstruction of the penis.
- Reconstruction of the fixed part of the urethra – associated surgical reconstruction with the scrotoplasty to create a scrotal complex.
- Scrotoplasty – creation of a penis from external genitalia, such as the labia majora, with or without testicular prosthesis insertion or implant.
- Subcutaneous mastectomy – removal of breast tissue, sparing the nipple-areola complex to create the male chest.
- Vaginectomy – removal of part or the entire vagina.
- Vaginoplasty – construction or reconstruction of the vaginal canal and may include neovaginoplasty, the partial or total construction of the vulvo-vaginal complex.
- Vulvoplasty – a reduction of the labia and may be known as a labiaplasty.

Regulatory Status

Gender reassignment surgical procedures are surgical interventions and, as such, are not subject to regulation by the FDA. The devices and medications/combinations of medications used in the treatment of gender dysphoria are subject to FDA approval or clearance. Refer to

the FDA web site at <https://www.fda.gov> for additional information on devices and medications that may be utilized for treatment.

Rationale

This policy is based on the Standards of Care for the Health of Transgender and Gender Diverse People (Version 8) from World Professional Association for Transgender Health (WPATH). (8)

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	11950, 11951, 11952, 11954, 11980, 11981, 11982, 11983, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879, 17380, 19300, 19316, 19318, 19325, 19340, 19342, 21120, 21121, 21122, 21123, 21125, 21127, 30400, 30410, 30420, 30430, 30435, 30450, 53430, 54125, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54520, 54660, 54690, 55175, 55180, 55970, 55980, 56625, 56800, 56805, 56810, 57106, 57107, 57110, 57111, 57291, 57292, 57295, 57296, 57335, 57426, 58150, 58180, 58260, 58262, 58275, 58280, 58285, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720, 90845, 90846, 90847, 90849, 90853, 90863
HCPCS Codes	J1071, J1073, J2320, J3121, J3145, [Deleted 1/2026: S0189]

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

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8. Coleman E, Radix AE, Bouman WP, et al. WPATH – Standards of Care for the Health of Transgender and Gender Diverse People, Eighth Version (September 2022). Available at <https://www.wpath.org> (accessed April 24, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
01/01/2026	Document updated. The following changes were made to Coverage: 1) Revised/updated the Adolescent criteria for surgery and related services. 2) Note 1 removed. Added references 2 and 4 and some removed.
09/15/2024	Reviewed. No changes.
04/15/2024	Document updated with literature review. The following changes were made to coverage: 1) Removed the word children from Gender Reassignment Surgery and Related Services for Children and Adolescents 2) NOTE 3 changed to say: Health care professionals should consider gender-affirming genital procedures for eligible transgender and gender diverse adults seeking these interventions when there is evidence the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired

	surgical result, unless hormone therapy is either not desired or is medically contraindicated) and 3) statement added under Criteria for Coverage of Gender Reassignment Surgery and Related Services for Adults: "For individuals undergoing gonadectomy who are not taking hormones, a plan for hormone replacement can be developed with their prescribing professional prior to surgery." References 5 and 22 added; others updated, and some removed.
05/01/2023	Document updated with literature review. The following changes were made to coverage: 1) Under Gender Reassignment Pharmaceutical Services statement: added "Implantable testosterone pellets (once appropriate dosing is stabilized)", and 2) Under Children and Adolescents statement: added "The capacity to make a fully informed decision and to consent for treatment; and Completion of one year of testosterone treatment prior to breast removal (FtM)" and 3) "Reached the age of majority" from Adult coverage criteria. Note 1 reworded adding criteria for nonbinary individuals, now stating "The adolescent is stable on their gender affirming hormonal treatment regime (which may include at least 12 months of gender-affirming hormone therapy or longer, if required) to achieve the desired surgical result for gender-affirming procedures", (unless hormone therapy is either not desired or is medically contraindicated) and "The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment." References 1, 3 and 7 added; others removed.
12/01/2021	Document updated with literature review. The following change was made to Coverage: Modified statement on hair removal. No new references added.
01/15/2021	Document updated with literature review. Coverage unchanged. Added references 21 and 22.
05/01/2019	Document updated with literature review. Coverage unchanged. Several definitions added in Description section. Reference 7 added; none removed.
03/15/2018	Document updated with literature review. The following changes were made to coverage: 1) Clarification of the required referrals prior to any surgery or related service(s); 2) The new coverage statements for gender primary or secondary sexual characteristic revision surgeries – "When there is documented evidence of physical functional impairment, gender primary or secondary sexual characteristic revision procedures or services are considered medically necessary. When there is no documented evidence of physical functional impairment, gender primary or secondary sexual characteristics revision services are considered not medically necessary (refer to appropriate procedure-specific policy)"; and, 3) The new coverage statements for reversal of gender reassignment surgical procedures – "Reversal of any of the prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics, the patient

	must meet the same criteria for gender dysphoria to have those reversal procedures considered medically necessary. If the criteria for gender dysphoria is not met, then reversal of any prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics is considered not medically necessary." The following was removed from coverage: 1) "See related medical policies below for information regarding related procedures or services for non-gender reassignment services because other exclusions may apply"; and 2) the listing of all medical policies addressing non-surgical related services and surgical related services.
10/01/2016	Document updated with literature review. Coverage unchanged. Speech-language therapy recommendations included in Rationale.
11/06/2015	Document updated with literature review. Multiple coverage changes from experimental, investigational and/or unproven to medically necessary for primary and secondary gender reassignment surgeries and related services. Coverage statements added for those individuals reaching the age of majority. Rationale and References updated and reorganized.
07/01/2014	Document updated with literature review. Coverage unchanged. CPT/HCPCS code(s) updated.
03/15/2013	Document updated with literature review. Coverage unchanged. The following was added: Gender reassignment surgery and related services, for those members with a contract or a certificate of coverage that would allow for gender reassignment surgery, when specific criteria are met. Title changed from Gender Reassignment Surgery to Gender Assignment Surgery and Gender Reassignment Surgery with Related Services. Policy removed from no further review status.
04/01/2008	Policy reviewed without literature review; new review date only. This policy is no longer scheduled for routine literature review and update.
05/01/2006	New medical document