DISCLAIMER

Our medical policies are designed for informational purposes only and are not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

POLICY

I. Medical Treatments of Gender Dysphoria

   A. Psychotherapy to treat gender dysphoria may be considered medically necessary

   B. The American Congress of Obstetricians and Gynecologists (ACOG) and the Endocrine Society (ES) guidelines describe continuous hormone therapy to treat gender dysphoria, which may be considered medically necessary when all of the following criteria are met:

      1. Documentation in the clinical records that the individual has the capacity to make fully informed decisions and to consent for treatment; and
      2. Is diagnosed with gender dysphoria (as defined by the DSM-5 criteria) by a licensed mental health practitioner; and
      3. Prior to the initiation of hormone therapy, at least one of the following criteria must have been met for a period of 3 or more months:

         a) Documentation of living as the desired gender; and/or
         b) Psychotherapy with a licensed mental health practitioner; and
4. Documentation that hormone therapy is being provided by a physician (MD/DO) who is:
   a) Board-certified in endocrinology; or
   b) Board certified in Obstetrics/Gynecology; or
   c) Part of a multi-disciplinary team, and able to provide documentation of specialized training in the treatment of this condition; and

5. Treatments are individualized and monitored utilizing applicable laboratory testing, as described below.

Please refer to University of California, San Francisco: Center of excellence for transgender health for detailed criteria and dosing regarding feminizing hormone treatment protocol for male-to-female transition and appropriate laboratory testing schedule (Deutsch, 2016).

http://www.transhealth.ucsf.edu/tcoe?page=guidelines-feminizing-therapy

Please refer to University of California, San Francisco: Center of excellence for transgender health for detailed criteria and dosing regarding masculinizing hormone treatment protocol for female-to-male transition and appropriate laboratory testing schedule (Deutsch, 2016).

http://www.transhealth.ucsf.edu/trans?page=guidelines-masculinizing-therapy

Please refer to University of California, San Francisco: Center of excellence for transgender health for detailed criteria and dosing regarding adolescent hormone treatment protocol for suppression of endogenous puberty, induction of amenorrhea, gender-affirming hormone regimen, and appropriate laboratory testing schedule (Olson-Kennedy, Rosenthal, Hastings, & Wesp, 2016).

http://www.transhealth.ucsf.edu/trans?page=guidelines-youth

Medications and dosages not consistent with these guidelines may be denied as investigational. Please note: There are varying expert medical opinions regarding the appropriate age to begin hormonal treatments. Not all clinics offer puberty suppression because of the ethical challenges associated with treatment and because there is very limited scientific literature to support treatment in children. Hormonal treatment in children and adolescents also carries risks (some are reversible and some are not) and most children who identify with the gender opposite their natal sex will desist (see Description below). Therefore, puberty suppression treatment will be considered investigational before age 12 years or Tanner stage 2-3 whichever is later and gender affirming hormone treatment will be considered investigational before age 16 in accordance with the Endocrine Society’s, WPATH’s, and American Academy of Pediatrics’ published guidelines (listed below in Practice Guidelines and Position Statements) (Hembree, Cohen-Kettenis, Delemarre-van de Waal, & et al., 2009; World Professional Association for Transgender Health, 2015; Levine, 2013).

II. Surgical Treatments of Gender Dysphoria
   A. Gender confirmation surgery, such as hysterectomy, salpingo-oophorectomy, ovariectomy, or orchiectomy may be considered medically necessary when all of the following criteria are met:
1. The individual is at least 18 years of age; and

2. The individual has capacity to make fully informed decisions and to consent for treatment; and

3. The individual has been diagnosed with gender dysphoria (as defined by the DSM-5 criteria) by a licensed mental health practitioner, and exhibits all of the following:
   a) The desire to live and be accepted as a member of the opposite sex and to make his or her body gender-congruent through surgical and hormone treatment; and
   b) The transsexual identity has been present persistently for at least two years; and
   c) The condition is not a symptom of another mental disorder; and
   d) The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

4. The individual has undergone a minimum of 12 months of continuous hormonal therapy (unless medically contraindicated) when recommended by a mental health professional and provided under the supervision of a physician; and

5. The individual has any significant medical or mental health issues reasonably well controlled. For individuals diagnosed with severe psychiatric disorders and impaired reality testing (for example: psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), a documented effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

6. The surgeon is part of a multi-disciplinary team, and able to provide documentation of specialized training in the treatment of this condition and

7. A referral letter is provided from a qualified mental health provider who has assessed the individual for gender dysphoria, which may be the individual’s psychotherapist. A second referral letter must also be provided from a provider who has only completed an independent evaluation and has not had a psychotherapy relationship with the individual.

At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) or a master’s level degree in a clinical behavioral science field (for example, M.S.W., Psychiatric Nurse Practitioner [N.P.], Licensed Professional Counselor [L.P.C.], or Marriage and Family Therapist [M.F.T.]) and be capable of adequately evaluating co-morbid psychiatric conditions. The list of specific criteria required in the letters of referral is found under Policy Guidelines below.

B. Gender confirmation surgeries, such as metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses, may be considered medically necessary when all of the following criteria are met:

1. The individual is at least 18 years of age; and

2. The individual has capacity to make fully informed decisions and to consent for treatment; and
3. The individual has been diagnosed with gender dysphoria (as defined by the DSM-5 criteria) by a licensed mental health practitioner, and exhibits all of the following:
   a) The desire to live and be accepted as a member of the opposite sex and to make his or her body gender-congruent through surgical and hormone treatment; and
   b) The transsexual identity has been present persistently for at least two years; and
   c) The condition is not a symptom of another mental disorder; and
   d) The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

4. The individual has undergone a minimum of 12 months of continuous hormonal therapy (unless medically contraindicated) when recommended by a mental health professional and provided under the supervision of a physician; and

5. Clinical documentation that indicates the individual has pre-operatively completed a minimum of 12 months of successful, continuous experience living in the gender role that is identity-congruent across a wide range of life experiences and events that may occur throughout the year; and

6. Regular participation in psychotherapy throughout the 12 months continuous experience living in the gender identity-congruent role when recommended by a treating medical or mental health practitioner; and

7. The individual has any significant medical or mental health issues reasonably well controlled. For individuals diagnosed with severe psychiatric disorders and impaired reality testing (for example: psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), a documented effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

8. The surgeon is part of a multi-disciplinary team, and able to provide documentation of specialized training in the treatment of this condition; and

9. A referral letter is provided from a qualified mental health provider who has assessed the individual for gender dysphoria, which may be the individual’s psychotherapist. A second referral letter must also be provided from a provider who has only completed an independent evaluation and has not had a psychotherapy relationship with the individual.

At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) or a master's level degree in a clinical behavioral science field (for example, M.S.W., Psychiatric Nurse Practitioner [N.P.], Licensed Professional Counselor [L.P.C.], or Marriage and Family Therapist [M.F.T.]) and be capable of adequately evaluating co-morbid psychiatric conditions. The list of specific criteria required in the letters of referral is found under Policy Guidelines below.

**Not Medically Necessary:**

When one or more of the criteria above have not been met, gender confirmation surgery is considered not medically necessary.
MP 2.01.201
Transgender Services

III. The following procedures are considered cosmetic as they are primarily intended to enhance appearance, and therefore not eligible for coverage as a treatment for GD:

1. Abdominoplasty
2. Blepharoplasty
3. Breast augmentation
4. Breast reduction/mastectomy (unless criteria for reduction mammoplasty is met; see BCI MP 7.01.21. Also see BCI MP 7.01.13 regarding treatment of gynecomastia)
5. Brow lift
6. Calf implants
7. Electrolysis
8. Face lift
9. Facial bone reconstruction, reduction, or enhancement
10. Facial implants
11. Glansplasty
12. Gluteal augmentation
13. Hair removal/hairplasty, (unless to treat a tissue donor site for an approved surgical procedure)
14. Jaw reduction (jaw contouring)
15. Lip reduction/enhancement
16. Lipofilling/collagen injections
17. Liposuction
18. Nose implants
19. Pectoral implants
20. Penile prosthesis
21. Rhinoplasty
22. Thyroid cartilage reduction (chondrolaryngoplasty)
23. Voice modification surgery
24. Voice therapy

Revisions and Reversals

Except in the case of a serious medical barrier to completing gender confirmation or the development of a serious medical condition necessitating reversal, surgery to reverse partially or fully completed gender confirmation is considered not medically necessary.

Revision surgery for cosmetic reasons or unsatisfactory aesthetic results is not an inherent component of the gender confirmation process or an untoward complication; therefore, revision surgery for these reasons is considered not medically necessary.

POLICY GUIDELINES

The letter or letters from treatment providers, as required above in Surgical Treatments of Gender Dysphoria, must contain documentation of the following:

1) The credentials of the author of the letter and professional relationship with the patient; and
2) The initial and evolving gender of the patient and other psychiatric diagnoses; and
3) The duration of their professional relationship including the type of psychotherapy or evaluation that the individual underwent; and

4) The eligibility criteria that have been met by the individual; and

5) The physician or mental health professional’s rationale for surgery; and

6) The degree to which the individual has followed the treatment and experiential requirements to date and the likelihood of future compliance; and

7) The extent of participation in psychotherapy throughout the pre-operative 12 month continuous experience living as the gender-congruent identity, (if such therapy is recommended by a treating medical or behavioral health practitioner); and

8) That the individual has, intends to, or is in the process of acquiring a legal gender identity-appropriate name change; and

9) The start date of the pre-operative 12-month continuous living experience; and

10) Demonstrable progress on the part of the individual in consolidating the new gender identity, including improvements in the ability to handle the following:

   a) Work, family, and interpersonal issues;

   b) Behavioral health issues, should they exist. This implies satisfactory control of issues such as:

      i) Sociopathy;

      ii) Substance abuse;

      iii) Psychosis;

      iv) Suicidality

11) A letter of documentation must be received from the treating surgeon. If one of the previously described letters (i.e., Surgical treatments of Gender Dysphoria II.A.7. & and II.B.9. ) is from the treating surgeon then it must confirm that:

   a) The candidate meets the criteria listed in this policy; and

   b) The treating surgeon feels that the individual is likely to benefit from surgery; and

   c) The surgeon has personally communicated with the treating mental health provider or physician treating the individual; and

   d) The surgeon has personally communicated with the individual and that the individual understands and consents to the ramifications and permanence of surgery (i.e., risks, benefits, and alternatives).

This policy is intended to support Section 1557 of the Patient Protection and Affordable Care Act of 2010. The Department of Health and Human Services noted in a summary of the Final Rule Implementing Section 1557:

Section 1557 builds on prior Federal civil rights laws to prohibit sex discrimination in health care. The final rule requires that women be treated equally with men in the health care they receive and also prohibits the denial of health care or health coverage based on an individual’s sex, including
discrimination based on pregnancy, gender identity, and sex stereotyping. The final rule also requires covered health programs and activities to treat individuals consistent with their gender identity.

**BACKGROUND**

The following policy addresses the medical and surgical treatment for transgender persons who desire to transition from one sex to another (gender confirmation) because of a marked incongruence between experienced/expressed gender and assigned gender (APA, 2013). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines the incongruence in gender identity that is associated with clinically significant distress or impairment in important areas of functioning, as gender dysphoria (APA, 2013). See Appendix for complete DSM-5 criteria.

The sex a newborn is assigned at birth (i.e., male or female) is called their *natal sex* and is based upon an assessment of genital anatomy or chromosomes. Gender identity is a person's internal sense of being male, female, or something else and *transgender* is an umbrella term for persons whose gender identity, gender expression, or behavior does not conform to their natal sex (American Psychological Association, 2016). Usually, people identify with the gender of their natal sex, which is called *cis-gender*.

Identification with other than one’s natal sex may start in early childhood and *persist* through adolescence. However, research has shown that most children who identify with the gender opposite of their natal sex will desist, which means their gender identity may change as they get older to become congruent with their natal sex (de Vries & Cohen-Kettenis, 2012; Wallien & Cohen-Kettenis, 2008). It has been noted that the trajectory for gender non-congruence in childhood is not predictable, but the majority of children will *desist* (Steenasma, van der Ende, Verhulst, & Cohen-Kettenis, 2013; Drescher & Byne, 2012). However, non-congruent gender identity that begins in childhood and persists into adolescence, or worsens with puberty, is less likely to change (Wallien & Cohen-Kettenis, 2008; Malpas, 2011; Steensma, McGuire, Kreukels, & et al., 2013). A non-congruent gender identity can persist from adolescence into adulthood. *Gender non-conformity* is the extent to which an individual’s gender identity, role, or expression diverges from cultural norms in a binary sexual system (Institute of Medicine, 2011). The American Psychiatric Association (APA) (2013) has identified that some transgender persons may suffer from a condition defined as *Gender Dysphoria* (GD). Gender dysphoria can affect people who have a strong and persistent desire to live according to their gender identity, rather than their natal sex. Gender Dysphoria was previously called *Gender Identity Disorder* (GID), but the APA changed the name in an attempt to remove the stigma attached to defining it as a disorder. Some transgender individuals experience gender dysphoria and may seek mental health services, medical, and/or surgical treatments to alleviate symptoms associated with the condition. Not all transgender or gender-nonconforming persons have difficulty with their gender identity, gender expression, or behavior, and not all transgender persons suffer from gender dysphoria. Studies into the etiology (i.e., cause) of gender dysphoria have not produced a satisfactory explanation of the phenomena, which have included studies from both the biological and psychosocial fields (Hembree, Cohen-Kettenis, Delemarre-van der Waal, & et al., 2009).

**Medical and Surgical Treatment Options for Gender Dysphoria**

Gender Dysphoria must be clinically diagnosed prior to treatment. Psychotherapy, hormone therapy, and in some cases surgical sex confirmation procedures are the treatments recommended for gender dysphoria. Psychotherapy is often the first medical treatment sought, which is often followed by
hormone therapy. Not all transgender individuals on hormone therapy choose to undergo gender-confirmation surgery, because surgery is irreversible, may lead to sexual dysfunction, chronic pain, infections, fistulas, and multiple corrective surgeries (World Professional Association for Transgender Health, 2015).

Psychotherapy
Psychotherapy is provided by a mental health professional prior to hormone therapy and/or surgical intervention. Psychotherapy should include documentation of an initial assessment of gender identity, dysphoria severity, and the historical development of gender dysphoric feelings (Coleman, et al., 2011). The goals of therapy are to assess, diagnose, and discuss treatment options.

Hormone Therapy
Hormone therapy is undertaken in order to feminize or masculinize the body to conform to the individual’s identified gender. For transgender individuals, hormone therapy produces the development of many secondary sexual characteristics of their desired sex. Hormone therapy treatment differs depending upon the natal sex of the individual. For Male-to-Female (MTF) individuals, hormone treatment may include estradiol, finasteride, and spironolactone. For Female-to-Male (FTM) individuals, hormone treatment may include androgenic hormones, such as testosterone.

Surgical Treatment
Surgical treatment for gender dysphoria differs depending upon the natal sex of the individual and the individualized treatment plan. Gender confirmation surgery is not a singular surgical procedure but a complex process involving a team of medical professionals, including but not limited to, psychiatrists, medical and surgical specialists. The World Professional Association for Transgender Health (WPATH) opined “surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon” (Coleman, et al., 2011, p. 203). Before undertaking gender confirmation surgery, important medical and psychological evaluations, medical therapies, and behavioral trials should be undertaken to confirm that surgery is the most appropriate treatment choice for the individual.

For individuals’ seeking MTF surgery, surgical treatment may include removal of the testicles and penis, and the creation of a pseudo-vagina, clitoris, and labia. Complications of MTF genital surgery may include necrosis of the vagina and labia, neovaginal prolapse, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and small or short vagina (Bucci, 2014).

For individuals’ seeking FTM surgery, surgical treatment may involve removal of the uterus, ovaries, and vagina. Surgical treatment for FTM transformation is a multi-stage reconstruction process and requires several surgeries, such as creation of a neophallus and scrotum. Surgical techniques for penile reconstruction vary and complications may include frequent urinary tract stenoses or fistulas, scarring at the donor site, and necrosis of the neophallus (Coleman, 2011; Selvaggi, 2012).

Refer to member contract language for benefit coverage of transgender services, including but not limited to, gender confirmation surgery.
Rationale

Several professional societies have issued position statements supporting healthcare standards and guidelines for the care of transgender persons. The following are some of the professional societies that have issued supportive statements or clinical guidelines: American Medical Association, American Psychological Association, American Academy of Family Physicians, National Association of Social Workers, American Public Health Association, American Congress of Obstetricians and Gynecologists, and the World Professional Association for Transgender Health (WPATH). Of these, WPATH is the only multidisciplinary professional advocacy group that is concerned with the health of transgender persons. Of note, the American Psychiatric Association has not yet issued clinical guidelines on the appropriate treatment of GD.

Practice Guidelines and Position Statements

World Professional Association for Transgender Health

In 2011, WPATH published Standards of Care for the Transsexual, Transgender, and Gender Nonconforming People, Version 7 (SOC) (Coleman, et al., 2011). The SOC “articulates standards of care while acknowledging the role of making informed choices and the value of harm reduction approaches” (Coleman, et al., 2011, p. 165). The SOC also acknowledges that treatment for gender dysphoria has become more individualized and flexible; for example, some persons with gender dysphoria will seek health care that is less invasive (e.g., hormone therapy only and not surgery).

A step-wise approach to therapy for adults with gender dysphoria, including accurate diagnosis and long-term treatment by a multidisciplinary team including behavioral, medical and surgical specialists, has been shown to provide the best results. As with any treatment of a mental health condition, a thorough behavioral analysis by qualified practitioners is needed. Once a diagnosis of gender dysphoria is established, treatment with hormone therapy, and an establishment of 12 months continuous experience living as the gender-congruent identity may be warranted. Hormone therapy, when indicated, should be administered under ongoing medical supervision and is an important step in beginning the gender transition process by altering body hair, breast size, skin appearance, skin texture, body fat distribution, the size and function of sex organs. Guidelines published by WPATH describe surgical procedures as “irreversible changes to the body” that present significant medical and psychological risks (Coleman, et al., 2011, p. 200). Gender confirmation surgery should be considered only after the above described trials have been undertaken, evaluated, and confirmed.

Experience living as the desired identity-congruent gender is important to validate the individual's desire and ability to incorporate their desired gender role within their social network and daily environment. This generally involves gender-specific appearance (e.g., clothing, hairstyle, grooming), involvement in various activities in the desired gender role including work or academic settings, legal acquisition of a gender appropriate first name, and acknowledgement by others of their new gender role. With regard gender identity-congruent living experience, the 2012 WPATH document specifically states:

The criterion noted above 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. As noted in section
VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can 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. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable (Coleman, et al., 2011, pp. 202-203).

If the surgical gender confirmation process is undertaken, there may be various additional aesthetic surgical procedures which may be sought in order to enhance the physical gender transformation. However, conflicting opinions exist regarding whether these procedures are essential in treating gender dysphoria. It is noted by WPATH, “opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive” (Coleman, et al., 2011, p. 201). Surgical intervention is not recommended for children or adolescents and should not be considered until at least age 18 after the individual has lived for at least 12 months in a gender-congruent role (Coleman, et al., 2011).

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

It is noted that the developmental course, treatment approaches, and phenomenology (i.e., the study of phenomena) is very different in children and adolescents with GD than for adults (Coleman, et al., 2011). The WPATH guidelines note that there is more variability in outcomes particularly with pre-pubertal children because of the physical, psychological, and sexual changes that occur as part of the developmental process. In fact, research has found that the dysphoria experienced by pre-pubertal children will not persist into adulthood in a majority of children (Wallien & Cohen-Kettenis, 2008) (Zucker & Bradley, 1995; Cohen-Kettenis, 2001; Drummond, Bradley, Peterson-Badali, & Zucker, 2008).

The assessment, psychosocial, and medical interventions for children and adolescents is often provided from a multi-disciplinary team that specialize in gender identity disorders in children (Coleman, et al., 2011). WPATH guidelines for physical interventions for adolescents follow the guidelines published by the Endocrine Society (see below). Endocrine Society

The Endocrine Society in conjunction with European Society of Endocrinology, European Society for Pediatric Endocrinology, Lawson Wilkins Pediatric Endocrine Society, and WPATH published guidelines regarding the treatment of transsexual persons (Hembree, Cohen-Kettenis, Delemarre-van de Waal, & et al., 2009). Of note, the guidelines were published when Gender Dysphoria was called Gender Identity Disorder; the appropriate changes are noted below. The guidelines employed transparent methods for evidence review and for rating the quality of evidence. All recommendations were based upon evidence which was rated to be low quality [emphasis added]. Hormonal treatment of adolescents is divided into three categories: fully reversible interventions, partially reversible interventions, and irreversible interventions (Hembree et al., 2009). A summary of the Endocrine Society guidelines are listed below:
Diagnostic Procedure
1. We recommend that the diagnosis of gender identity disorder (GID) [GD] be made by a mental health professional (MHP). For children and adolescents, the MHP should also have training in child and adolescent developmental psychopathology.

2. Given the high rate of remission of GID [GD] after the onset of puberty, we recommend against a complete social role change and hormone treatment in pre-pubertal children with GID [GD].

3. We recommend that physicians evaluate and ensure that applicants understand the reversible and irreversible effects of hormone suppression (e.g. GnRH analog treatment) and cross-sex hormone treatment before they start hormone treatment.

4. We recommend that all transsexual individuals be informed and counseled regarding options for fertility prior to initiation of puberty suppression in adolescents and prior to treatment with sex hormones of the desired sex in both adolescents and adults.

Treatment of Adolescents
1. We recommend that adolescents who fulfill eligibility and readiness criteria for gender confirmation initially undergo treatment to suppress pubertal development.

2. We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively), but no earlier than Tanner stages 2–3.

3. We recommend that GnRH analogs be used to achieve suppression of pubertal hormones.

4. We suggest that pubertal development of the desired opposite sex be initiated at about the age of 16 year, using a gradually increasing dose schedule of cross-sex steroids.

5. We recommend referring hormone-treated adolescents for surgery when:
   - the real-life experience (RLE) has resulted in a satisfactory social role change;
   - the individual is satisfied about the hormonal effects; and
   - the individual desires definitive surgical changes.

6. We suggest deferring surgery until the individual is at least 18 year old.

Hormonal Therapy for Transsexual Adults
1. We recommend that treating endocrinologists confirm the diagnostic criteria of GID [GD] or transsexualism and the eligibility and readiness criteria for the endocrine phase of gender transition.

2. We recommend that medical conditions that can be exacerbated by hormone depletion and cross-sex hormone treatment be evaluated and addressed prior to initiation of treatment.

3. We suggest that cross-sex hormone levels be maintained in the normal physiological range for the desired gender.

4. We suggest that endocrinologists review the onset and time course of physical changes induced by cross-sex hormone treatment.

Adverse Outcome Prevention and Long-term Care
MP 2.01.201
Transgender Services

1. We suggest regular clinical and laboratory monitoring every 3 months during the first year and then once or twice yearly.
2. We suggest monitoring prolactin levels in male-to-female (MTF) transsexual persons treated with estrogens.
3. We suggest that transsexual persons treated with hormones be evaluated for cardiovascular risk factors.
4. We suggest that bone mineral density (BMD) measurements be obtained if risk factors for osteoporosis exist, specifically in those who stop hormone therapy after gonadectomy.
5. We suggest that MTF transsexual persons who have no known increased risk of breast cancer follow breast screening guidelines recommended for biological women.
6. We suggest that MTF transsexual persons treated with estrogens follow screening guidelines for prostatic disease and prostate cancer recommended for biological men.
7. We suggest that female-to-male (FTM) transsexual persons evaluate the risks and benefits of including total hysterectomy and oophorectomy as part of sex confirmation surgery.

Surgery for Sex Confirmation
1. We recommend that transsexual persons consider genital sex confirmation surgery only after both the physician responsible for endocrine transition therapy and the MHP find surgery advisable.
2. We recommend that genital sex confirmation surgery be recommended only after completion of at least 1 year of consistent and compliant hormone treatment.
3. We recommend that the physician responsible for endocrine treatment medically clear transsexual individuals for sex confirmation surgery and collaborate with the surgeon regarding hormone use during and after surgery.

American Congress of Obstetricians and Gynecologists
The American Congress of Obstetricians and Gynecologists (ACOG) published a committee opinion regarding health care services for transgendered individuals (American Congress of Obstetricians and Gynecologists, 2011). The following recommendations were made by ACOG, “Obstetricians–Gynecologists should be prepared to assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies. Hormonal and surgical therapies for transgender patients may be requested, but should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender patients” (ACOG, 2011, para. 7). In addition, ACOG (2011) guidelines made specific recommendations regarding hormone therapy, surgery and screening for both female-to-male and male-to-female patients:

Female-to-Male Transgender Individuals

Hormones
Methyl testosterone injections every 2 weeks are usually sufficient to suppress menses and induce masculine secondary sex characteristics. Before receiving androgen therapy, patients should be screened for medical contraindications and have periodic laboratory testing, including hemoglobin and
hematocrit to evaluate for polycythemia, liver function tests, and serum testosterone level assessments (goal is a mid-normal male range of 500 microgram/dL), while receiving the treatment.

**Surgery**
Hysterectomy, with or without salpingo-oophorectomy, is commonly part of the surgical process. An obstetrician–gynecologist who has no specialized expertise in transgender care may be asked to perform this surgery, and also may be consulted for routine reasons such as dysfunctional bleeding or pelvic pain. Reconstructive surgery should be performed by an urologist, gynecologist, plastic surgeon, or general surgeon who has specialized competence and training in this field.

**Screening**
Age-appropriate screening for breast cancer and cervical cancer should be continued unless mastectomy or removal of the cervix has occurred. For patients using androgen therapy who have not had a complete hysterectomy, there may be an increased risk of endometrial cancer and ovarian cancer.

**Male-to-Female Transgender Individuals**

**Hormones**
Estrogen therapy results in gynecomastia, reduced hair growth, redistribution of fat, and reduced testicular volume. All patients considering therapy should be screened for medical contraindications. After surgery, doses of estradiol, 2–4 mg/dL, or conjugated equine estrogen, 2.5 mg/dL, are often sufficient to keep total testosterone levels to normal female levels of less than 25 ng/dL. Non-oral therapy also can be offered. It is recommended that male-to-female transgender patients receiving estrogen therapy have an annual prolactin level assessment and visual field examination to screen for prolactinoma.

**Surgery**
Surgery usually involves penile and testicular excision and the creation of a neovagina. Reported complications of surgery include vaginal and urethral stenosis, fistula formation, problems with remnants of erectile tissue, and pain. Vaginal dilation of the neovagina is required to maintain patency. Other surgical procedures that may be performed include breast implants and nongenital surgery, such as facial feminization surgery.

**Screening**
Age-appropriate screening for breast and prostate cancer is appropriate for male-to-female transgender patients. Opinion varies regarding the need for Pap testing in this population. In patients who have a neocervix created from the glans penis, routine cytologic examination of the neocervix may be indicated. The glands are more prone to cancerous changes than the skin of the penile shaft, and intraepithelial neoplasia of the glans is more likely to progress to invasive carcinoma than is intraepithelial neoplasia of other penile skin.

**REFERENCES**


**CODES**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>53400</td>
<td>Urethroplasty; first stage, for fistula, diverticulum, or stricture (e.g., Johannsen type)</td>
</tr>
<tr>
<td></td>
<td>53405</td>
<td>Urethroplasty; second stage (formation of urethra), including urinary diversion</td>
</tr>
<tr>
<td></td>
<td>53410</td>
<td>Urethroplasty, 1-stage reconstruction of male anterior urethra</td>
</tr>
<tr>
<td></td>
<td>53415</td>
<td>Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra</td>
</tr>
<tr>
<td></td>
<td>53420</td>
<td>Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage</td>
</tr>
<tr>
<td></td>
<td>53425</td>
<td>Urethroplasty, 2-stage reconstruction of repair of prostatic or membranous urethra; second stage</td>
</tr>
<tr>
<td></td>
<td>53430</td>
<td>Urethroplasty, reconstruction of female urethra</td>
</tr>
<tr>
<td></td>
<td>54120</td>
<td>Amputation of penis; partial</td>
</tr>
<tr>
<td></td>
<td>54125</td>
<td>Amputation of penis; complete (Penectomy)</td>
</tr>
<tr>
<td></td>
<td>54520</td>
<td>Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach</td>
</tr>
<tr>
<td></td>
<td>54660</td>
<td>Insertion of testicular prosthesis</td>
</tr>
<tr>
<td></td>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy</td>
</tr>
<tr>
<td></td>
<td>55175</td>
<td>Scrotoplasty; simple</td>
</tr>
<tr>
<td></td>
<td>55180</td>
<td>Scrotoplasty; complicated</td>
</tr>
<tr>
<td></td>
<td>55899</td>
<td>Phallic reconstruction/Phalloplasty (Unlisted procedure, male genital system)</td>
</tr>
<tr>
<td></td>
<td>55970</td>
<td>intersex surgery; male to female</td>
</tr>
<tr>
<td></td>
<td>55980</td>
<td>intersex surgery; female to male</td>
</tr>
<tr>
<td></td>
<td>56800</td>
<td>Plastic repair of introitus</td>
</tr>
<tr>
<td></td>
<td>56805</td>
<td>Clitoroplasty for intersex state</td>
</tr>
<tr>
<td></td>
<td>57106</td>
<td>Vaginectomy, partial removal of vaginal wall</td>
</tr>
<tr>
<td></td>
<td>57110</td>
<td>Vaginectomy, complete removal of vaginal wall;</td>
</tr>
<tr>
<td></td>
<td>57291</td>
<td>Construction of artificial vagina; without graft</td>
</tr>
<tr>
<td></td>
<td>57292</td>
<td>Construction of artificial vagina; with graft</td>
</tr>
<tr>
<td></td>
<td>57295</td>
<td>Revision (including removal) of prosthetic vaginal graft; vaginal approach</td>
</tr>
<tr>
<td></td>
<td>57296</td>
<td>Revision (including removal) of prosthetic vaginal</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>57335</td>
<td>Vaginoplasty for intersex state - the physician uses various plastic surgery techniques to correct a small, underdeveloped vagina due to the overproduction of male hormones</td>
<td></td>
</tr>
<tr>
<td>57426</td>
<td>Revision (including removal) of prosthetic vaginal graft, laparoscopic approach</td>
<td></td>
</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>
<td></td>
</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>
<td></td>
</tr>
<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy;</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>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less</td>
<td></td>
</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>
<td></td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g</td>
<td></td>
</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>
<td></td>
</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>
<td></td>
</tr>
<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less</td>
<td></td>
</tr>
<tr>
<td>58571</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
<td></td>
</tr>
</tbody>
</table>
MP 2.01.201
Transgender Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58572</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58573</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58720</td>
<td>Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)</td>
</tr>
<tr>
<td>58999</td>
<td>Labiaplasty</td>
</tr>
</tbody>
</table>

ICD-10-CM  Investigational for all relevant diagnoses
ICD-10-PCS  ICD-10-PCS codes are only for use on inpatient services. There is no specific ICD-10-PCS code for this procedure.

POLICY HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/17</td>
<td>New policy - Add to Medicine section</td>
<td>Local policy created with literature review on gender reassignment services</td>
</tr>
<tr>
<td>01/30/18</td>
<td>Replace local policy</td>
<td>Blue Cross of Idaho annual review; no change to policy.</td>
</tr>
</tbody>
</table>

APPENDIX

DSM-5 Criteria for Gender Dysphoria

*Gender Dysphoria in Children:*

1. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one’s assigned gender)
   2. In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
   3. A strong preference for cross-gender roles in make-believe play of fantasy play.
   4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
   5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

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

*Specify if:*

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 2.55.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen insensitivity syndrome) Coding note: Code the disorder of sex development as well as gender dysphoria.

*Gender Dysphoria in Adolescents and Adults:*

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).

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