Priority Health

MEDICAL POLICY
No. 91612-R8

GENDER AFFIRMING SURGERY

Effective Date: January 1, 2026

Review Dates: 8/15, 8/16, 11/16, 8/17, 8/18, 8/19, 8/20, 5/21, 8/21, 8/22, 11/22, 5/23, 11/23, 11/24, 11/25

Date Of Origin: August 12, 2015

Status: Current

Note: Policy was previously titled Gender Reassignment Surgery

Summary of Changes

Addition:

- Breast augmentation is a medically necessary gender affirming chest surgery when criteria are met.
- Age limit for government sponsored plans.

Clarification:

- Removed asterisks and notes when applicable.

I. POLICY/CRITERIA

Determination of the medical necessity of surgical, non-surgical, and/or related services for the treatment of gender dysphoria is independent of the determination of whether the treatment is a covered benefit. Coverage for services varies across plans and is defined in benefit or plan documents. For coverage details, including exclusions or limitations, refer to member specific plan documents. Coverage for services may also be governed by state and/or federal law, mandates, or other regulatory rules.

For government sponsored programs and plans see plan documents for age minimum and/or other limitations.

Gender affirming surgery (GAS), including pre- and post-surgical hormone therapy, is considered medically necessary when **ALL** of the following criteria are met:

1. Diagnosis of gender incongruence/dysphoria made by licensed practitioner with expertise in gender dysphoria, incongruence, and diversity, and
2. Capacity to make a fully informed decision and to consent for treatment, and
3. Acknowledge aftercare requirements and importance of pre- and post-operative aftercare requirements, and
4. Gender affirming surgical procedure is completed by surgeon with training and active practice in gender-affirming surgical procedures, and
5. Age 18 or older or as permitted by regulatory rules, OR age 19 or older for government sponsored programs and plans.

If medically necessary criteria for coverage for gender affirming surgery are met, the following conditions of coverage apply:

A. Gender affirming chest surgery (i.e., initial mastectomy, breast reduction, breast augmentation) is considered medically necessary when the criteria below are met:
   1. Breast augmentation for members assigned male at birth:
      i. An initial breast reconstruction surgery is medically necessary.
      ii. Completion of a minimum of 6 months of hormone therapy prior to breast augmentation surgery without sufficient breast development.
   2. Breast reduction for members assigned female at birth:
      i. An initial mastectomy is medically necessary.
         a. Trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

B. Gonadectomy (Hysterectomy and salpingo-oophorectomy assigned female at birth and orchiectomy in assigned male at birth) when **BOTH** of the following additional criteria are met:

   1. Documentation of at least 6 months of continuous hormonal therapy for gender incongruence/ dysphoria.
   2. Documentation of permanence resultant proposed GAS

C. Genital Reconstructive surgery (i.e., including colpectomy vaginectomy, urethroplasty, metoidioplasty with initial phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in patients assigned female at birth; including colovaginoplasty penectomy, vaginoplasty, labiaplasty, and clitoroplasty repair of introitus, construction of vagina with graft, coloproctostomy in patients assigned male at birth) when **ALL** of the following criteria are met:

   1. Documentation of at least 6 months of continuous hormonal therapy for gender incongruence/ dysphoria (May be simultaneous with real life experience), ***AND***
   2. The individual has lived within the desired gender role for at least 12 continuous months, which includes a wide range of life experiences and events (e.g., family events, holidays, vacations, season-specific work or school experiences), including notification to partners, family, friends, and community members (e.g., at school, work, other settings) of their identified gender, ***AND***

3. The individual is an active participant in a recognized multidisciplinary (i.e., medical, mental health, and surgery) treatment program.

D. A limited number of electrolysis or laser hair removal sessions may be considered medically necessary for skin graft preparation for genital surgery.

E. The procedures listed below may be considered medically necessary only when performed as part of a component of a comprehensive facial feminization or facial masculinization service performed as an adjunct to gender affirming surgery (items A, B, or C, as above) following a diagnosis of gender dysphoria:

Feminization/Masculinization Procedures	CPT/HCPCS Code(s)
Adjacent tissue transfer or rearrangement (forehead, cheeks, chin, mouth)	14041
Blepharoplasty An isolated procedure not completed as a component of a comprehensive feminization or masculinization service, is subject to the terms, conditions, limitations, and medical necessity criteria specified in Priority Health Medical Policy *91535 – Cosmetic and Reconstructive Surgery Procedures*	15820, 15821, 15822, 15823
Brow lift An isolated procedure not completed as a component of a comprehensive feminization or masculinization service, is subject to the terms, conditions, limitations, and medical necessity criteria specified in Priority Health Medical Policy *91535 – Cosmetic and Reconstructive Surgery Procedures*	67900
Cheek/malar implants	17999
Chin/nose implants, chin recontouring	21210, 21270, 30400, 30410, 30420, 30430 30435, 30450
Collagen injections, limited to facial	11950, 11951, 11952, 11954

Face lift	15824, 15825, 15826, 15828, 15829
Forehead reduction and contouring	21137, 21139
Facial bone reduction (osteoplasty)	21209
Grafting of autologous soft tissue	15769
Jaw reduction, contouring, augmentation	21120, 21121, 21122, 21123, 21125, 21127, 21193
Laryngoplasty	31599
Reconstruction superior-lateral orbital rim and lower forehead	21172
Rhinoplasty An isolated procedure not completed as a component of a comprehensive feminization or masculinization service, is subject to the terms, conditions, limitations, and medical necessity criteria specified in Priority Health Medical Policy *91535 – Cosmetic and Reconstructive Surgery Procedures*	21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450
Skin resurfacing (e.g., dermabrasion, chemical peels) limited to facial	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Thyroid reduction chondroplasty	31750
Electrolysis (i.e., face, neck) and limited to eight 30-minute timed units per day	17380
Suction assisted lipoplasty, lipofilling, and/or liposuction (i.e., head, neck)	15839, 15876

F. Procedures associated with gender affirmation surgery that are performed solely for the purpose of improving or altering appearance or self-esteem related to one's appearance, are considered cosmetic in nature and not medically necessary.

The following are considered cosmetic in nature and not medically necessary when performed as a component of a gender affirmation, even when there is a benefit for gender affirming surgery (this list may not be all-inclusive):

1. Forehead augmentation
2. Gluteal and hip augmentation
3. Hair reconstruction (transplantation or removal, except as noted in I D above)

4. Liposuction and lipofilling, non-facial
5. Mastopexy
6. Nipple/areola reconstruction
7. Pectoral implants
8. Skin resurfacing, non-facial (e.g., dermabrasion, chemical peel)
9. Voice modification surgery

G.
Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male trans-identified persons who have not undergone a mastectomy.
2. Prostate cancer screening may be medically necessary for male to female trans-identified persons who have retained their prostate.

H. Reversal of gender affirming surgery is not a covered benefit.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

III. APPLICATION TO PRODUCTS

Gender affirming surgery, including pre- and post-hormone therapy, is a covered service to the extent as required, limited, and/or enforceable by applicable state and/or federal law, and the above criteria are met, including being provided by a facility approved in advance by Priority Health. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Any procedure or treatment that is not medically/clinically necessary or is considered cosmetic, experimental or investigational, is not covered.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***

- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IV. BACKGROUND

Gender-affirmation surgery (GAS) refers to a constellation of procedures designed to align a person's body with their gender identity. Recognizing the diverse and heterogeneous community of individuals who identify as transgender and gender diverse (TGD), gender-affirming surgical interventions may be categorized along a spectrum of procedures for individuals assigned male at birth (AMAB) and assigned female at birth (AFAB).

Hormone replacement therapy (HRT) plays an important role in the gender associated medical and surgical treatment (GAMST) process. Patients assigned male at birth are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Treatment with estrogen and testosterone-lowering medications will induce feminine and reduce masculine physical characteristics. The most studied physical change in transgender women is the development of breast tissue (T'Sjoen, 2019). An Italian cohort study found increases in breast size were the only physical feature that was significantly associated with improvement in body uneasiness scores (Fisher, 2016). A study of 229 transgender women participating in the European Network for the Investigation of Gender Incongruence cohort found that breast development reached a plateau within the first 6 months of therapy and half of the transgender women had a AAA cup size or less (de Block, 2018). Patients assigned female at birth are treated with testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes HRT may be effective in reducing the adverse psychologic impact of gender incongruence/ dysphoria.

Gender incongruence /dysphoria undergoes what is referred to as a "real life experience", prior to irreversible genital surgery, in which he/she adopts the new or evolving gender role and lives in that role as part of the transition pathway.

This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During this time, a person would be expected to maintain their baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Gender affirmation surgery is intended to be a permanent change, establishing congruency between an individual's gender identity and physical appearance and is not easily reversible. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine, and urological examination, and a clinical psychiatric/psychological examination.

Regret after GAS can be temporarily or permanent and may be classified as (Narayan et al., 2021) social regret (caused by difficulties in familial, religious, social, or professional life), medical regret (due to long-term medical complications, disappointment in surgical results of inadequate preoperative decision-making), and true gender-related regret (mostly based on patient experienced misdiagnosis, insufficient exploration of gender identity, or both).

Surgeons offering GAS may have a variety of surgical specialty training and backgrounds. The most common surgical specialties include plastic surgery, urology, gynecology, otolaryngology and oro-maxillofacial surgery (Jazayeri et al., 2021). Surgeons offering care for TGD people have received documented training in gender-affirming procedures and principles of gender-affirming care (Schechter et al., 2017; Schechter & Cohen 2019).

V. CODING INFORMATION

ICD-10 Codes *that* **must** *be reported on claims and preauthorization requests relative to gender reassignment procedures:*

F64.0	Transsexualism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

CPT/HCPCS Codes that may apply:
L*ist should not be considered complete nor a guarantee of coverage:*

55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
17380	Electrolysis epilation, each 30 minutes
19318	Breast reduction

53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
56625	Vulvectomy, simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

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