GEHA
Government Employees Health Association

Corporate Medical Policy

Implementation 1/1/2024

Gender Affirmation Surgery

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Description of Procedure or Service

Gender Dysphoria is characterized by a marked incongruence between one's experienced or expressed gender and one's assigned gender, of at least six months duration, which causes clinically significant distress or impairment in social, school, occupational, or other important areas of functioning. Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (US Institute of Medicine, 2011).

Gender Affirmation Surgery refers to surgery or a series of surgical procedures designed to change a person's physical appearance and sexual function with intent to alleviate dysphoria and discomfort caused by incongruent gender identity. Surgical treatment of gender dysphoria modifies primary and/or secondary sex characteristics to establish greater congruence with the individual's gender identity and may include the following: clitoroplasty, hysterectomy, labiaplasty, mastectomy, orchiectomy, penectomy, phalloplasty or metoidioplasty (alternative to phalloplasty), placement of testicular and/or penile prostheses, salpingo-oophorectomy, scrotoplasty, urethroplasty, vaginectomy, vaginoplasty, and vulvectomy.

Additional procedures to address secondary sexual characteristics may be appropriate in certain circumstances to address dysphoria within the social role related to gender identity. These may include hair removal, grafting, or hairline advancement; body contouring specific to gender affirmation; facial contouring such as jaw and/or chin reshaping; lip shortening; or voice modification surgery.

Benefit Application

Surgical treatment of gender dysphoria such as surgical change of sex characteristics including bilateral mastectomy, augmentation mammoplasty, genital reconstructive surgeries (vulvoplasty, orchiectomy, urethroplasty, penectomy, vaginoplasty, labiaplasty and clitoroplasty, hysterectomy/ salpingo-oophorectomy, reconstruction of the fixed part of the urethra, metoidioplasty, phalloplasty, colpectomy/ vaginectomy, colpoclesis, perineoplasty, vulvectomy, scrotoplasty, implantation of erection and/or testicular prosthesis); pectoral muscle implants; hair removal including genital electrolysis, non-

genital area electrolysis or laser hair removal (e.g., face, chest); liposuction/lipofilling specific to gender affirmation; facial gender affirming surgeries such as genioplasty, jaw and/or chin reshaping, rhinoplasty, blepharoplasty, brow ptosis repair, lip shortening, scalp (hairline) advancement, hair grafts; voice modification including vocal feminization and masculinization surgery.

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits.

Policy Statement

GEHA will provide coverage for gender affirmation surgery when it is determined to be medically necessary because the medical criteria and guidelines as documented below have been demonstrated.

When gender affirmation surgery is covered

Gender affirmation surgery may be considered medically necessary when all of the criteria listed below are met:

A. Must be 18 years of age or older
B. Gender incongruence is marked and sustained for at least 12 months duration and is demonstrated by at least two of the following:
    1. A marked incongruence between one's experienced or expressed gender and their assigned gender or primary and/or secondary sex characteristics, or
    2. A strong desire to be rid of one's primary and/or secondary sex characteristics because these do not align with the individuals experienced or expressed gender, or
    3. A strong desire for the primary and/or secondary sex characteristics of another gender, or
    4. A strong desired to be another gender (either the opposite binary gender or some alternative gender or a gender differing from one's assigned gender), or
    5. A strong desire to be treated as another gender, or
    6. A strong conviction that one has the typical feelings and reactions of another gender; and
C. The patient's condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
D. The patient demonstrates the capacity to make a fully informed decision and consent for surgical treatment; and
E. The patient understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options and/or fertility preservation if desired. (Please see the Infertility Services coverage policy); and
F. Other possible causes of gender incongruence have been identified and excluded; and
G. All mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical interventions have been assessed, with risks and benefits discussed; and
H. The patient has lived full time in a gender role congruent with their gender identity for 12 months; and
I. The patient is stable on their gender affirming hormonal treatment regime, when appropriate, for a minimum of 12 months*

1. Patients undergoing multiple or staged procedures may be required to pause hormonal treatment regimen temporarily during the pre- and/or post- operative period. Disruptions of this nature will not be considered instability in hormone treatment regime, but the duration of time hormones were not taken will not count toward required time frame(s) for hormonal treatment.
2. Relative contraindications to hormonal therapy may include, but are not limited to:
    i. Estrogen: high risk of cardiovascular disease, osteoporosis, history of certain cancers (e.g. breast, uterine, ovarian, testicular, prostate), history of venous thromboembolism, thrombophilia, or tobacco use.
    ii. Testosterone: severe uncontrolled hypertension, sleep apnea, polycythemia, , history of certain cancers (e.g. breast, uterine, ovarian, testicular, prostate)

*For certain procedures, different duration of hormone treatment may be required, as indicated below; and

J. The patient is under the care of a multidisciplinary team including endocrinology, surgery, primary care, and qualified behavioral health professionals with expertise in gender-affirming care; and
K. The patient has received a recommendation from a qualified behavioral health professional who has personally assessed the patient, which includes support for the patient to undergo gender affirmative surgical procedures for the treatment of gender dysphoria; and
L. The patient is aware of all recommended post-surgical care, is agreeable to following recommended after care protocols, and patient has access to anticipated support and accommodations (i.e. self or caregiver willing to provide wound care, transportation to follow up appointments, ability to follow activity restrictions, time of work or school as needed, ongoing dilation, etc.)

Additional criteria are required for certain procedures, as outlined below.

For chest/breast surgery:

Mastectomy

NOTE: The Women's Health and Cancer Rights Act (WHCRA), 29 U.S. Code § 1185b requires coverage of certain post-mastectomy services related to breast reconstruction and treatment of physical complications from mastectomy including nipple-areola reconstruction.

A. The patient meets all criteria A-K above, when applicable, and all required documentation is provided, and
B. The patient does not have any contraindication or conditions which exclude them from coverage (please see non-covered section).
C. *When mastectomy is performed as a stand-alone procedure, the requirement for hormone therapy is waived.

Augmentation mammoplasty

A. The patient meets all criteria A-K above, when applicable, and all required documentation is provided, and
B. The patient does not have any contraindication or conditions which exclude them from coverage (please see non-covered section).
C. *Patient is stable on their gender affirming hormonal treatment regime for a minimum of 12 months, and
D. The patient's breast growth has concluded, and breast size been stable for at least 6 months, and
E. The patient still experiences clinically significant dysphoria specifically related to breast size insufficiency which causes discomfort in their social role related to gender.

For genital surgery:
Penile inversion procedure for creation of neovagina is the standard of care. Other techniques (e.g. peritoneal flap) for initial procedure will require additional review and documentation of the medical need to utilize specified surgical technique.

A. The patient meets all criteria A-K above, when applicable, and all required documentation is provided, and
B. The patient does not have any contraindication or conditions which exclude them from coverage (please see non-covered section).
C. Patient's anatomy does not provide sufficient tissue to create adequate neovaginal width (6cm minimum) and depth (14 cm minimum) through penile inversion and scrotal tissue grafts alone.

For facial, head, and neck surgery:
Gender affirming surgical procedures on the face, head, and neck are limited to: hair removal (laser or electrolysis), genioplasty, jaw reshaping, chin reshaping, rhinoplasty, blepharoplasty, brow ptosis repair, lip shortening, scalp (hairline) advancement, hair grafting, and voice modification surgery (phonosurgery).

A. The patient meets all criteria A-K above, when applicable, and all required documentation is provided, and
B. The patient does not have any contraindication or conditions which exclude them from coverage (please see non-covered section).
C. The patient experiences clinically significant dysphoria specifically related to the features on which procedures will be performed, which causes discomfort in their social role related to gender.

For voice surgery (phonosurgery):

Coverage may include cricothyroid approximation (CTA), thyrohyoid approximation, endoscopic laser assisted voice adjustment (LAVA), endoscopic laser reduction glottoplasty (LRG), and pitch-lowering (relaxation) laryngoplasty.

A. The patient meets all criteria A-K above, when applicable, and all required documentation is provided, and
B. The patient does not have any contraindication or conditions which exclude them from coverage (please see non-covered section), and

C. The patient has participated in a minimum of 8 weeks of voice therapy performed by a licensed speech language pathologist, and
D. The patient still experiences clinically significant dysphoria specifically related to the voice, which causes discomfort in their social role related to gender.

For body contouring

Coverage is limited to liposuction, lipofilling, and pectoral implants specific to gender affirmation.

A. The patient meets all criteria A-K above, when applicable, and all required documentation is provided, and
B. The patient does not have any contraindication or conditions which exclude them from coverage (please see non-covered section).
C. Body fat redistribution and muscle mass changes related to hormone therapy have stabilized for at least 3 months, and
D. The patient experiences clinically significant dysphoria specifically related to the features on which procedures will be performed, which causes discomfort in their social role related to gender.

For revision surgery (including phalloplasty, scrotoplasty, metoidioplasty, vaginoplasty, vulvoplasty, augmentation mammoplasty, mastectomy, facial procedures, body contouring):

A. Patient has medical complications related to surgery, including but not limited to:
    1. Urinary tract function (stricture, fistula, mucocele, diverticula, infection, hair growth within neourethra), or
    2. Prosthetic complications (infection, malfunction, erosion, rupture, dislocation), or
    3. Vaginal stenosis despite compliant serial dilation, intra-vaginal hair growth, fistulas (e.g. rectovaginal); and
B. Patient has been compliant with follow up care including home care, follow up appointments, activity restriction, and other post-operative instructions from their surgeon or medical team, and
C. Conservative management of surgical complications have been exhausted, are not appropriate, or cannot be reasonable expected to resolve the complication adequately.

When gender affirmation surgery is not medically necessary

A. Gender affirmation surgery is considered not medically necessary when one or more of the criteria above have not been met.
B. Gender affirming procedures not specifically listed above, such as: face-lifting, reduction thyroid chondroplasty, augmentation thyroid chondroplasty, jaw implant, calf implants, mons lift/ mons reduction, chin or nose implants, forehead contouring, malar (cheek) implants, buttocks implant, transgender reversal unless secondary to surgical complications.
C. Reversal or revision of gender affirmation surgery, unless secondary to surgical complications, is not a benefit of the plan. Revision surgery requested for aesthetic or cosmetic considerations when no functional impairment is present is not a benefit of the plan.

D. Cosmetic surgery is defined as any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated promptly or as soon as the member's condition permits is considered a non-covered benefit under the GEHA Service Benefit Plan.

Procedures which are non-standard are considered experimental or investigational and are not a benefit of the plan.

A. Non-standard procedures may include, but are not limited to, vaginoplasty other than penile inversion technique when adequate tissue is available for inversion surgery; vaginoplasty utilizing emerging technologies such as amnion grafting, cell culture, or buccal free-graft; uterine, ovarian, vaginal, penile, or testicular transplantation, or other procedures not explicitly listed as covered.

Physician documentation

- Physician notes documenting the patient's condition including:
    - History of condition
    - Detailed outline of patient's deficits cause by gender dysphoria, including recurrent distress or functional impairment in social, occupational, school, or other areas. Specific patient concerns, distress, and disfunction related to facial features, voice, and/or body areas/regions causing concern, anxiety, distress, and/or dysphoria must be clearly outlined for consideration of surgical treatment of impacted body regions.
    - History of any current or previous treatments for gender dysphoria, including hormone therapy, with dates initiated and discontinued, and the reason(s) for discontinuing treatment when applicable.
        - If hormone treatment has not been part of the treatment plan, please describe any relative or absolute contraindications to hormone therapy.
    - Comprehensive treatment plan including all phases of treatment (past, current, and future proposed) and specific surgical techniques planned.
    - Post-operative patient care protocols (wound care, follow-up appointments, activity modification, etc.) and documentation of patient or caregiver ability and willingness to comply with recommended post-operative care plan.
- A written psychological assessment from one qualified behavioral health professional experienced in treating gender dysphoria, who have personally and independently assessed the patient. The assessment must include:
    - Opinion on the patient's capability to make a fully informed decision and consent for treatment.
    - The patient must be at least 18 years of age.
    - Detail of any significant medical or mental health conditions which are present, and documentation of the treatment plans and efficacy of treatments showing the conditions are reasonably well controlled.
    - Confirmation that the patient has completed at least 12 months of successful continuous full-time, real-life experience in the gender with which they identify.

- Documentation that the patient has completed a minimum of 12 months continuous of the duration of hormone therapy appropriate for the gender with which they identify or documentation of medically contraindication to hormone therapy use.
- Practitioner's professional opinion and support or recommendation, when appropriate, for specific surgical procedure(s) being requested for treatment of gender dysphoria due to incongruence.

Additional documentation criteria for specific surgical procedures:

For augmentation mammoplasty:

1. The Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role, and
2. Dated serial measurements documenting cessation of continued breast growth related to gender affirming hormone therapy.

For Voice Surgery (Phonosurgery)

1. Speech therapy notes documenting inability to adequately address patient's communication goals through speech therapy, and
2. Specific voice qualities (pitch (F_o), resonance, etc.) causing patient concerns, distress, and disfunction related to voice.

For Body Contouring

1. Dated serial measurements of body areas to be treated documenting cessation of body fat and/or muscle redistribution related to gender affirming hormone therapy.

Revision surgery

1. Documentation of specific surgical complications to be addressed by revision, and
2. Documentation of all previously attempted treatments to resolve surgical complications, and
3. Notes detailing patient's adherence to previously recommended post-operative protocols.

<u>Policy Guidelines</u>

The DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents are:

1) 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:
   A) 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)
   B) 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)
   C) A strong desire for the primary and/or secondary sex characteristics of the other gender
   D) A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)

E) A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
F) 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)

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

In 2017, the Endocrine Society issued an updated clinical practice guideline: Gender Dysphoria/Gender Incongruence Guideline Resources (Hembree, et.al., 2017). The essential points include the following:

- Diagnosing clinicians, mental health providers for adolescents, and mental health professionals for adults all should be knowledgeable about the diagnostic criteria for gender-affirming treatment, have sufficient training and experience in assessing related mental health conditions, and be willing to participate in the ongoing care throughout the endocrine transition.
- Gender-dysphoric/gender-incongruent persons should receive a safe and effective hormone regimen that will suppress the body's sex hormone secretion, determined at birth, and manifested at puberty, and maintain levels of sex steroids within the normal range for the person's affirmed gender.
- Hormone treatment is not recommended for pre-pubertal gender-dysphoric /gender-incongruent persons.
- For the care of youths during puberty and older adolescents, an expert multi-disciplinary team comprised of medical professionals and mental health professionals should manage treatment;
- For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient;
- All individuals seeking gender-affirming medical treatment should receive information and counsel on options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy in both adolescents and adults;
- Removal of gonads may be considered when high doses of sex steroids are required to suppress the body's secretion of hormones, and/or to reduce steroid levels in advanced age; and
- During sex steroid treatment, clinicians should monitor, in both transgender males (female to male) and/or transgender females (male to female), prolactin, metabolic disorders, and bone loss, as well as cancer risks in individuals who have not undergone surgical treatment.

The Endocrine Society issued Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline in September 2009 (Hembree, 2009). The recommendations included position statements regarding sex reassignment surgery: 1. Patients should consider genital SRS only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery advisable. 2. Genital SRS is recommended only after completion of at least 1 year of consistent and compliant hormone treatment. 3. The physician responsible for endocrine treatment should medically clear transsexual individuals for SRS and collaborate with the surgeon regarding hormone use during and after surgery. 4. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery.

In 2021, the American College of Obstetricians and Gynecologists issued the following position statement:

- Transgender and gender diverse individuals, like all people, must have access to respectful, equitable, evidence-based care, free from discrimination and political interference.
- Policies that dictate medical practice, restrict patient-clinician communications, and criminalize or penalize clinicians for practicing according to their professional judgement and training represent dangerous and ill-advised interference in quality, ethical patient care.
- Efforts to affirm and uplift the civil, human, and reproductive rights of the LGBTQIA and gender diverse communities should be supported at all levels, from the individual clinical environment to the government.
- Evidence, science, and the needs of patients should drive public health policies (ACOG Committee Opinion number 823, 2021).

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the Standards of Care (WPATH, 2012). These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and patients share responsibility for the decision to make irreversible changes to the body.

There is a National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9) effective on August 30, 2016, which states CMS determined that no NCD is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with GD. In the absence of an NCD, coverage determinations will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8(2022) provides the following recommendations for minimum credentials in mental health professionals who work with adults presenting with gender dysphoria:

1. Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
2. Competence in using the latest version of the World Health Organization's International Classification of Diseases (ICD) for diagnostic purposes.
3. Ability to recognize and diagnose coexisting mental health or other psychosocial concerns and to distinguish these from gender dysphoria, incongruence, and diversity.
4. Are able to assess capacity to consent for treatment.
5. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.

6. Undergo continuing education in health care related to gender dysphoria, incongruence, and diversity. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition, it is recommended that health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required.

Surgical treatments for gender dysphoria can be initiated by a qualified mental health professional. The mental health professional provides documentation—in the chart and/or referral letter—of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

The recommended content of the referral letters for surgery is as follows:
1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this (WPATH, 2012).

Background

For the purposes of this policy a **Qualified Behavioral Health Professional** shall mean:

A practitioner who has achieved a minimum of master's level degree, or the equivalent level of education in their field, from an accredited institution and documented credentials from a relevant licensing board. Potentially covered providers include Psychologist, Psychiatrist, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Alcohol and Drug Abuse Counselor, Licensed Independent Social Worker, Licensed Clinical Social Worker, or Academy of Certified Social Worker. The provider should have competence in the Diagnostic Statistical Manual of Mental Disorders (DSM) and/or International Classification of Diseases (ICD) for diagnostic purposes. The provider must have the education and experience to recognize and diagnose coexisting mental health concerns and to distinguish other conditions from gender dysphoria.

Gender identity is defined as a personal conception of oneself as male or female (or rarely, both or neither). This concept is intimately related to the concept of gender role, which is defined as the outward manifestations of personality that reflect the gender identity. Gender identity, in nearly all instances, is self-identified, as a result of a combination of inherent and extrinsic or environmental factors; gender role, on the other hand, is manifested within society by observable factors such as behavior and appearance (Ghosh, 2020)

Gender Identity Disorder is characterized by the following diagnostic criteria: 1.) A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). 2.) Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. The disturbance is not concurrent with a physical intersex condition. The disturbance causes

clinically significant distress or impairment in social, occupational, or other important areas of functioning. 3.) The transsexual identity has been present persistently for at least two years. 4.) The disorder is not a symptom of another mental disorder or a chromosomal abnormality (Byne et. al., 2011).

Surgical treatment of gender dysphoria is intended to be a permanent change to a patient's sexual identity and is not 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, endocrinological urological examination, and a clinical psychiatric/psychological examination. A patient's self-evaluation and desire for sex reassignment are not considered a reliable indicator of GID.

Procedures for the chest, also known as "top surgery", and those for the groin and reproductive organs, also known as "bottom surgery", do not need to be done in conjunction. Additionally, individuals undergoing top surgery do not need to subsequently undergo bottom surgery, or vice versa. The selection of appropriate procedures should be based on the needs of the individual in relation to the treatment of their diagnosis of gender dysphoria.

A study was conducted in 2015 (Ruppin & Pfafflin) to examine long term outcomes of gender reassignment for individuals with GID. To meet the inclusion criterion, the legal recognition of participants' gender change via a legal name change had to date back at least 10 years. The sample comprised 71 participants (35 MtF and 36 FtM). The follow-up period was 10–24 years with a mean of 13.8 years (SD = 2.78). Instruments included a combination of qualitative and quantitative methods: Clinical interviews were conducted with the participants, and they completed a follow-up questionnaire as well as several standardized questionnaires they had already filled in when they first made contact with the clinic. Positive and desired changes were determined by all of the instruments: Participants reported high degrees of well-being and a good social integration. Very few participants were unemployed, most of them had a steady relationship, and they were also satisfied with their relationships with family and friends. Their overall evaluation of the treatment process for sex reassignment and its effectiveness in reducing gender dysphoria was positive. Regarding the results of the standardized questionnaires, participants showed significantly fewer psychological problems and interpersonal difficulties as well as a strongly increased life satisfaction at follow-up than at the time of the initial consultation.

In a recent study by Van de Grift et. al. (2018), the surgical satisfaction and quality of life of individuals undergoing gender-affirming surgery was examined. The results of the study suggest that satisfaction with gender-affirming surgery is related to a variety of factors; although dissatisfaction may not be very prevalent, it can be viewed as an indicator of more impaired outcomes. Predicting dissatisfaction with postoperative outcomes is difficult, but the present data suggest associations with preoperative psychological symptoms and life satisfaction, as well as with self-reported complications at follow-up. Satisfaction with the relatively complicated phalloplasty procedure, before which participants are mostly thoroughly counseled by both the surgeon and the psychologist, was high. This may suggest that a concerted effort by specialized clinicians of both specialties may improve experienced outcomes.

Gooren et. al. (2008) established through clinical research that long-term treatment of transsexuals with cross-sex hormones seems acceptably safe over the short and medium term but solid clinical data are lacking.

In 2015, Schneider et. al. published research findings in relationship to testicular functions and clinical characterization of patients with gender dysphoria undergoing sex reassignment surgery and hormone therapy. The aim of this study was to compare the effects of three different hormonal treatment strategies regarding endocrinological parameters and testicular histology. Testicular tissues were obtained in a multicenter study from 108 patients on the day of SRS from three clinics following different treatment strategies. Patients either discontinued treatment 6 weeks (clinic A) or 2 weeks (clinic B) prior to SRS or not at all (clinic C). Testicular tissues, ethylenediaminetetraacetic acid blood and questionnaires were obtained on the day of SRS. According to the questionnaires, patients showed desired phenotypical changes including breast growth (75%) and smooth skin (32%). While patients from clinics A and B presented with rather virilized hormonal levels, patients from clinic C showed generally feminized blood serum levels. Histological evaluation revealed highly heterogeneous results with about 24% of patients presenting with qualitatively normal spermatogenesis. In accordance with serum endocrine profile, ITT levels were lowest in clinic C and correlated with testosterone and free testosterone, but not with the spermatogenic state. The percentage of LHCGR-positive cells and ITT levels did not correlate. Only patients that did not discontinue hormonal treatment showed feminized blood levels on the day of SRS. The ones who stopped re-virilized quickly.

Vaginoplasty

Horbach et al found in 2015 that penile skin invasion technique is the method of choice for most surgeons in the creation of a neovagina. They also note that the penile skin inversion technique is the most researched procedure. They recommend standardization protocols and prospective study designs for interpretation and comparability of data. Comparison between surgical techniques was difficult due to lack of standardization and heterogeneous patient groups.

Hontscharuk et al reported in 2021 that penile inversion vaginoplasty is favored by most surgeons. Complication rates are comparable to genitourinary procedures performed for other diagnoses (ie oncological or congenital). Patients have high rates of post-surgical satisfaction even when complications occur. Risk factors which seem to contribute to complications include advanced age, higher body mass index, diabetes, and smoking history. Additionally, non-compliance with post-operative protocols, including dilation instructions and activity restrictions, appears to have a high influence on post-operative complications and reached statistical significance with regard to rates of revision and reoperation. Cosmetic considerations are the primary reason patients seek reoperation following vaginoplasty. They conclude that penile inversion vaginoplasty is safe and effective treatment to alleviate gender dysphoria and improve quality of life.

Wei et al in 2017 and Seyed-Forootan in 2018 have reported on use of autologous buccal (cheek) flap graft and autologous fibroblast-seeded amnion, respectively. While these techniques show promise, the findings are preliminary and should be validated by bell-designed studies. The existing literature is considered Level IV and the appropriate patient selection and application of these techniques have yet to be elucidated.

Ferrando (2022) concludes that penile inversion vaginoplasty is the predominant approach for vaginoplasty at this time. However, additional techniques are needed for various reasons, such as limited tissue available due to puberty suppression or revision surgery related to stenosis or other poor surgical outcome following initial procedure. Intestinal vaginoplasty may use a portion of the bowel (ileum, jejunum, cecum, or sigmoid colon). This may reduce the risk of neovaginal contracture and

stenosis (compared to penile inversion), eliminate the need for postoperative vaginal dilation, and may provide natural lubrication. Disadvantages to this approach include morbidity of laparotomy (e.g. infection, wound dehiscence), shrinkage with intestinal stenosis, anastomotic dehiscence, possible need for colostomy, and persistent and copious secretion of colonic mucus. Intestinal vaginoplasty is more complicated than other neovaginal procedures and few surgeons perform this procedure.

Ferrando also found that peritoneal flap ("pull through") was a viable technique for creation of neovagina in patients with penoscrotal hypoplasia and may even be regarded by some as an appropriate primary procedure regardless of hypoplastic genital tissue. This approach seems to be associated with few adverse events when performed by experienced surgeons.

Hair

In 2016, Zhang et. al. found that laser hair removal (LHR) was superior for genital hair removal compared to electrolysis for areas used to create reconstructive flaps. Use of hair-bearing tissue in genital surgery may result in postoperative intra- vaginal and intra- urethral hair growth which causes complications.

Facial Procedures

In 2019, Jordan C Deschamps-Braly's commentary on Nonsurgical Management of Facial Masculinization and Feminization surgery refutes the recommendation for use of injectables such as neurotoxin (i.e. botulinum toxin) and fillers. "Although injectables may improve one's appearance and even make one appear more youthful, they do not provide the dramatic changes necessary for transitioning trans men or women. Most trans patients are savvy enough to realize that using nonsurgical modalities such as injections of Botox are not sufficient for them to be clearly identified as their preferred gender. Suggesting otherwise is truly a disservice to trans men and women… The authors also assert that augmentation of the lips, the cheeks, and nasolabial folds is feminizing. Cis-gender women and men alike suffer volume loss in these areas. Although augmentation of these areas may serve to improve youthfulness, this is a very different issue than gender."

Voice

Srivastava (2022) reports that only 41% of the perception of gender in voice is explained by fundamental frequencies (F_o). The remainder of the variance being accounted for by other parameters like resonance, intonation, breathiness, and formants frequencies. Pitch (the relative highness or lowness of a tone as perceived by the ear) depends on the number of vibrations per second produced by the vocal cords. Treatment with estrogen shows no improvement in their voice in everyday life communication. However, hormone therapy is beneficial for masculinizing the voice. Out of all the characteristics, only pitch (F_o) is amenable to surgical correction. Other features can be corrected by speech and behavioral therapy. Typical frequency ranges for masculine voice are 80-165 Hz, feminine voice 145-275 Hz; and an overlap range of 145-165 Hz which cannot be assigned to one gender uniquely. A comprehensive voice assessment is essential. This assessment should include pitch/fundamental frequencies, frequency range, jitter, maximum phonation time, phonation quotient, estimated subglottic pressure, and voice handicap index. A perceptual analysis using grade, roughness, asthenia, breathiness, and strain (GRBAS) Hirano scale. The voice assessment should be performed by a speech-language pathologist. Ongoing post-treatment voice assessment should be repeated at regular intervals.

Haben (2022) states pitch reduction may be accomplished by several therapeutic options, including speech and voice training, hormonal treatments, and surgical procedures. In transgender men, gender affirming hormone therapy in combination with voice retraining with laryngeal repositioning is considered first-line standard of care. After initiation of hormone therapy (specifically testosterone), voice deepening is expected within 3-12 months.

Schneider and Courey (2016) note that while hormone therapy in trans women results in a reduction of testosterone, there is no perceived significant effect on voice or perception of feminine voice. This is believed to be due to previous testosterone exposure causing irreversible hypertrophy of the laryngeal muscles, cartilage, and mucosa. Specialty trained speech language pathologists (SLPs) are best equipped to facilitate overall vocal health and efficiency, in addition to behavioral changes related to voice and communication for transgender people. Treatment should be patient specific and can be accomplished through behavioral and medical/surgical intervention. The components of voice production are primarily addressed through behavioral voice therapy.

Reproductive organ transplant

Reproductive organ transplantation is considered experimental at this time.

As of 2018, only 4 cisgender male patients worldwide have ever received a penile transplant. The procedure has never been attempted on a transgender male patient. As of 2019, only 3 known testicle transplants have been performed worldwide. All instances of testicular transplant were performed on cisgender male identical twins. The viability of the procedure for transgender men has not been explored. Post-transplant immunosuppressive therapy protocols are also unknown due to all previous instances occurring on sets of identical twins.

Jones et al reported in 2019 on 45 cases of uterine transplantation. All instances were performed on cisgender women. There is no data on performing uterine transplantation on transgender women at this time. In 2010, Donnez reported on three cases of allotransplantation of ovaries. All three recipients of allotransplantation were cisgender women who had previously received bone marrow transplants (BMT) from an HLA-compatible sister. The previous BMT resulted in chimerism. Ovarian allotransplantation was performed using ovarian donor tissue from the sister who had previously donated bone marrow. No immunosuppressive therapy was required due to chimerism. As of 2011, one birth has been reported. No instances of ovarian or ovary-uterine transplantation attempted on transgender women were found in literature. Therefore, these procedures are considered experimental at this time.

Regulatory Status

Surgical treatment of gender dysphoria is a procedure and, therefore, not subject to FDA regulation. However, any medical devices, drugs, biologics, or tests used as part of the procedure may be subject to FDA regulation.

Codes

The following codes are for reference purposes only and do not imply that the service is covered or non-covered.

ICD10 Applicable Codes

A. F64.0 Transsexualism
B. F64.1 Dual role transvestism
C. F64.2 Gender identity disorder of childhood
D. F64.8 Other gender identity disorders
E. F64.9 Gender identity disorder, unspecified
F. Z87.890 Personal history of sex reassignment

Procedures eligible for reimbursement only when criteria are met (this list may not be all inclusive)

Code	Description
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk) (List separately in addition to code for primary procedure)
15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma

15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid, with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid, with excessive skin weighting down lid
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	electrolysis epilation, each 30 minutes
17999	unlisted procedure, skin, mucous membrane, and subcutaneous tissue
19303	Mastectomy, simple, complete
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364	Breast reconstruction with free flap
19366	Breast reconstruction with other technique
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy

19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19396	Preparation of moulage for custom breast implant
19499	unlisted procedure, breast
21121	Genioplasty, sliding osteotomy, single piece
21122	Genioplasty, sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21141	Reconstruction midface, LeFort I, single piece, segment movement in any direction (eg for long face syndrome) without bone graft
21142	Reconstruction midface, LeFort I, 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I, 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I, single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	Reconstruction midface, LeFort I, 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I, 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg ungrafted bilateral alveolar cleft or multiple osteotomies)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy, without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy, with bone graft
21195	Reconstruction of mandibular rami and/or body, sagittal split, without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split, with internal rigid fixation
21209	Osteoplasty, facial bones, reduction
21299**	Unlisted craniofacial and maxillofacial procedure
30400	Rhinoplasty, primary, lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, complete, including major septal repair
30430	Rhinoplasty, secondary, minor revision (small amount of nasal tip work)
30435	rhinoplasty, secondary, intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary, major revision (nasal tip work and osteotomies)
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s) {not including absorbable nasal implants}
30999	Unlisted procedure, nose (when used to report the insertion of an absorbable nasal implant or radiofrequency of nasal valve)

31599**	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
40500	Vermilionectomy (lip shave), with mucosal advancement
40799	Unlisted procedure, lips
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type)
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
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
53450	Urethromeatoplasty, with mucosal advancement
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
53500	Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall;
57120	Colpocleisis (Le Fort type)
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)
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
64905	Nerve pedicle transfer; first stage
64907	Nerve pedicle transfer; second stage
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67950	Canthoplasty
C1789	Prosthesis, breast (implantable)
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable
L8600	Implantable breast prosthesis, silicone or equal
L8699**	Prosthetic implant, not otherwise specified

** Unlisted or unspecified procedures require specific description and may or may not be covered, based on the specific utilization, coding standards, and medical necessity review.

Non-Covered Codes

The following are not considered medically necessary because cosmetic surgery completed to improve the physical appearance is not a covered benefit under the GEHA Service Benefit Plan:

Code	Description
11950	Subcutaneous injection of filling material (eg. Collagen) 1 cc or less
11951	Subcutaneous injection of filling material (eg. Collagen), 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg. Collagen), 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg. Collagen) over 10.0 cc
15780	Dermabrasion, total face
15781	Dermabrasion, segmental, face
15782	Dermabrasion, regional, other than face
15783	Dermabrasion, superficial, any site
15786	Abrasion, single lesion
15787	Abrasion, each additional 4 lesions or less
15788	Chemical peel, facial, epidermal
15789	Chemical peel, facial, dermal
15792	Chemical peel, nonfacial, epidermal
15793	Chemical peel, nonfacial, dermal
15819	Cervicoplasty
15824	Rhytidectomy, forehead
15825	Rhytidectomy, neck with platysmal tightening
15826	Rhytidectomy, glabellar frown lines
15828	Rhytidectomy, cheek, chin, and neck
15829	Rhytidectomy superficial musculoaponeurotic system (SMAS) flap
15830†	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839†	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847†	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
19316	Mastopexy

21120	Genioplasty, augmentation
21125	Augmentation, mandibular body or angle, prosthetic material
21127	Augmentation, mandiblular body or angle, with bone graft, onlay or interpositional (includes obtaining autografts)
21137	Reduction forehead, contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21210	Graft, bone, nasal, maxillary or malar areas (includes obtaining graft)
21123	Genioplasty, sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21270	Malar augmentation, prosthetic material
31899†††	unlisted procedure, trachea, bronchi
67909	Reduction of overcorrection of ptosis
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
J0585	Injection, onabotulinumtoxinA, 1 unit
J0586	Injection, abobotulinumtoxinA, 5 units
J0587	Injection, rimabotulinumtoxinB, 100 units
J0588	Injection, incobotulinumtoxinA, 1 unit
J0591	Injection, deoxycholic acid, 1 mg
J3490	Unclassified drugs
J3590	Unclassified biologics
L8699††	Prosthetic implant, not otherwise specified
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg

† when used to describe a non-covered service mons lift or reduction

†† when used for a non-covered prosthetic implant device, including but not limited to nasal, jaw, chin, cheek, forehead, calf, or buttocks/gluteal implant

††† when used to describe augmentation or reduction chondroplasty of thyroid (adam's apple)

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Policy implementation and updates

Date	Update

Origination Date: Mar 2016 Peer Reviewed: Nov 2023 Next Review Date: Nov 2024

February 2019	Changed title of policy and content to reflect member benefit brochure terminology. Provided guideline for breast augmentation.
March 2020	Formatting change, clarification of coverage criteria. Background content and supporting guidelines added. No change in coverage.
March 2021	Added coverage of scrotoplasty. Background content added.
March 2022	Updated terminology to preferred nomenclature throughout. Combined mastectomy/augmentation mammoplasty to chest/breast surgery; combined hysterectomy, salpingo-oophorectomy, orchiectomy, and genital reconstructive procedures to genital and reproductive organ surgery. Changed required hormone therapy to 12 months. Clarified covered and non-covered procedures, including removing specific gender transition sections. Defined qualified behavioral health professional.
January 2023	Updated to allow coverage for facial feminization including jaw and/or chin reshaping, lip shortening, hair removal, hair transplant/grafts and/or hairline advancement, liposuction or lipofilling specific to gender affirmation, and voice modification surgery. Clarified criteria for different phalloplasty techniques. Updated criteria to only require one letter of recommendation for surgery and to align to current standards of care.
November 2023	Updated brochure benefit coverage to include the following: Surgical treatment of gender dysphoria such as surgical change of sex characteristics including bilateral mastectomy, augmentation mammoplasty, genital reconstructive surgeries (vulvoplasty, orchiectomy, urethroplasty, penectomy, vaginoplasty, labiaplasty and clitoroplasty, hysterectomy/ salpingo-oophorectomy, reconstruction of the fixed part of the urethra, metoidioplasty, phalloplasty, colpectomy/ vaginectomy, colpoclesis, perineoplasty, vulvectomy, scrotoplasty, implantation of erection and/or testicular prosthesis); pectoral muscle implants; hair removal including genital electrolysis, non-genital area electrolysis or laser hair removal (e.g., face, chest); liposuction/lipofilling specific to gender affirmation; facial gender affirming surgeries such as genioplasty, jaw and/or chin reshaping, rhinoplasty, blepharoplasty, brow ptosis repair, lip shortening, scalp (hairline) advancement, hair grafts; voice modification including vocal feminization and masculinization surgery. Updated corresponding coverage criteria. Updated Societal guidelines for ACOG and the Endocrine Society. Format changes. Update to coding to align with new coverage.