



Gender Dysphoria Treatment Medical Policy

Service: Gender Dysphoria Treatment

PUM 250-0039

Medical Policy Committee Approval	11/19/2020
Effective Date	01/01/2021
Prior Authorization Needed	Yes

Note: Some services listed in this policy may be specific exclusions of a member's health plan. Benefits vary by plan. Consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to these services.

This policy is based on the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version, Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), and American Psychiatric Association recommendations as well as other evidence based publications.

WPATH describes the transition from one gender to another in three stages:

1. Living in the gender role consistent with gender identity
2. The use of cross-sex hormone therapy after living in the new gender role for a least three months
3. Gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months.

WPATH recommends, "Physicians who perform surgical treatments for gender dysphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association."

Clinical evidence for many of these services is limited and lacks long term safety data. Statistically robust randomized controlled trials are needed to address benefits versus clinical risks and long term health outcomes. Expert consensus recommendations include that diagnosis be made by qualified mental health professionals and that care is coordinated between the behavioral health professional, endocrinologists, and experienced surgeons.

This medical policy does not apply to individuals with ambiguous (uncertain or more than one type of) genitalia or disorders of sexual development, unless there is concurrent / concomitant diagnosed gender dysphoria.

Related Medical Policies:

- Surgical Removal of Redundant Skin and Face/Neck Lift Procedures
- Septoplasty and Rhinoplasty
- Otoplasty and Reconstruction of External Ear
- Panniculectomy, Abdominoplasty, and Repair of Diastasis Recti



- Blepharoplasty, Blepharoptosis Repair, Brow lift, and Related Procedures
- Non-covered Services and Procedures

Description:

Gender dysphoria is a condition in which there is a marked incongruence (discrepancy or conflict) between an individual's physical or assigned (birth) gender and the gender with which the individual identifies.

Indications of Coverage:

In the absence of health plan limits, more than one gender transformation reassignment (which may include several staged surgeries) per lifetime will be considered experimental investigational and unproven.

When criteria / requirements below are met, the following gender reassignment surgical procedures may be considered medically necessary:

Female-to-Male (FtM)

1. Bilateral mastectomy
2. Hysterectomy (removal of uterus)
3. Metoidioplasty (creation of penis using clitoris)
4. Penile prosthesis
5. Phalloplasty (creation of penis)
6. Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
7. Scrotoplasty (creation of scrotum)
8. Testicular prosthesis
9. Urethroplasty (reconstruction of male urethra)
10. Vaginectomy (removal of vagina)
11. Vulvectomy (removal of vulva)
12. Bilateral mastectomy may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure.

Male-to-Female (MtF)

1. Clitoroplasty (creation of clitoris)



2. Labiaplasty (creation of labia)
3. Orchiectomy (removal of testicles)
4. Penectomy (removal of penis)
5. Urethroplasty (reconstruction of female urethra)
6. Vaginoplasty (creation of vagina)
7. Breast augmentation (augmentation mammoplasty and breast implants)

A. Requirements for mastectomy for female-to-male (FtM) individuals or breast augmentation (augmentation mammoplasty and breast implants) in male-to-female (MtF) individuals:

1. Single letter of referral from a *qualified mental health professional; and
 2. Persistent, well-documented gender dysphoria; and
 3. Capacity to make a fully informed decision and to consent for treatment; and
 4. Age 18 years or older; OR less than 18 years old with the consent of both parents.
 5. If significant medical or mental health concerns are present, they must be reasonably well controlled
- Note: A trial of hormone therapy is not a prerequisite (required or necessary) to qualify for a mastectomy
- It is recommended (although not required) that male-to-female individuals undergo feminizing hormone therapy for a minimum of 12 months prior to breast augmentation surgery in order to maximize breast growth and obtain better surgical results.

Note: More than one breast augmentation is considered not medically necessary.

B. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male individuals and orchiectomy in male-to-female individuals)

1. Two referral letters from *qualified mental health professionals (one in a purely evaluative role); and
2. Persistent, well-documented gender dysphoria; and
3. Capacity to make a fully informed decision and to consent for treatment; and
4. Age 18 years or older; OR less than 18 years old with the consent of both parents.



5. If significant medical or mental health concerns are present, they must be reasonably well controlled; and
6. Twelve months of continuous hormone therapy as appropriate to the individual's gender goals (unless the individual has a medical contraindication) or is otherwise unable or unwilling to take hormones)

C. Requirements for genital reconstructive surgery

1. Two referral letters from *qualified mental health professionals, one in a purely evaluative role; and
2. Persistent, well-documented gender dysphoria; and
3. Capacity to make a fully informed decision and to consent for treatment; and
4. Age 18 years or older; OR less than 18 years old with the consent of both parents.
5. If significant medical or mental health concerns are present, they must be reasonably well controlled; and
6. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); and
7. Twelve months of living in a gender role that is congruent with their gender identity (real life experience)

***Requirements for a Qualified Mental Health Professional:**

1. Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent; **and**
2. Competence in using the Diagnostic Statistical Manual of Mental Disorders (5th Edition, DSM-5) and/or the International Classification of Disease for diagnostic purposes; **and**
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; **and**
4. Knowledgeable about gender nonconforming identities and expressions; and the assessment and treatment of gender dysphoria; **and**
5. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars, obtaining supervision from a mental health professional with relevant experience, or participating in research related to gender nonconformity and gender dysphoria.



Hormone Treatment for Gender Dysphoria (e.g., Testosterone injection):

1. Criteria for starting hormone therapy requires documentation of:

- a. Persistent, well-documented gender dysphoria/gender incongruence
- b. Results of the client's physical and psychosocial assessment, including any diagnoses
- c. Relevant medical or mental health issues are well controlled
- d. The World Professional Association for Transgender Health (WPATH) criteria for hormonal treatment have been met.
- e. The patient's capacity to make a well-informed decision
- f. A statement that informed consent regarding the risks and benefits of hormonal treatment has been obtained
- g. Ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects
- h. Communication, as needed, with the patient's primary care provider, mental health professional, and surgeon

2. If member meets above criteria, then hormone treatment will be allowed consistent with that described in Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version, section VIII.

Note: Topical and oral testosterone/androgens are reviewed by Express Scripts. Testosterone/cypionate/enanthate may also be reviewed by Express Scripts when being self-administered.

Limitations of Coverage:

- A. Review health plan and endorsements for exclusions and prior authorization or benefit requirements.
- B. If used for a condition or diagnosis other than is listed in the Indications of Coverage, it will be denied as experimental, investigational, and unproven to affect health outcomes.
- C. If used for a condition or diagnosis that is listed in the Indications of Coverage; but the criteria are not met, it will be denied as not medically necessary.
- D. Reproductive services (including, but not limited to, sperm or oocyte preservation, cryopreservation of fertilized embryos) are often listed as Health Plan exclusions and will not be covered (unless mandated by Federal or State legislation).



- E. Certain ancillary procedures, including (**but not limited to**) the following, are exclusions of the health plan for all individuals or are considered cosmetic and will be denied, when performed as part of gender reassignment:
1. Abdominoplasty (tummy tuck)
 2. Bicep implantation
 3. Blepharoplasty (eyelid surgery). See medical policy: Blepharoplasty, Blepharoptosis Repair, Brow Lift, and Related Procedures for medical necessity criteria (Indications of Coverage) and Limitations of Coverage related to this.
 4. Body contouring or body sculpting (such as, but not limited to fat transfer, lipoplasty, panniculectomy, Ultherapy™, CoolSculpting™)
 5. Body lift procedures
 6. Brachioplasty (arm lift)
 7. Brow lift. See medical policy: Blepharoplasty, Blepharoptosis Repair, Brow Lift, and Related Procedures for medical necessity criteria [Indications of Coverage] and Limitations of Coverage related to this.
 8. Buttocks augmentation or buttocks enhancement procedures
 9. Calf implants
 10. Cheek, chin and nose implants
 11. Chemical peels
 12. Dermabrasion
 13. Face lift or forehead lift
 14. Facial bone remodeling for facial feminization
 15. Hair removal (such as electrolysis, laser hair removal, waxing)
 16. Hair transplantation
 17. Injection of collagen, fillers, or neurotoxins
 18. Lip augmentation
 19. Lip reduction
 20. Liposuction (suction-assisted lipectomy)
 21. Mastopexy



22. Neck tightening
23. Nipple/areola reconstruction
24. Otoplasty (ear shaping surgery)
25. Pectoral implants for chest masculinization
26. Removal of redundant skin
27. Reversal of genital surgery or reversal of surgery to revise secondary sexual characteristics
28. Rhinoplasty
29. Skin resurfacing (such as dermabrasion, chemical peels, laser)
30. Thighplasty (Thigh lift)
31. Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
32. Torso masculinization or feminization
33. Voice modification surgery (such as laryngoplasty, glottoplasty, cricothyroid approximation, or shortening of the vocal cords)
34. Voice lessons or voice therapy

Documentation Required:

- Referral letters from a *qualified mental health professional containing all of the following:
 1. Client's general identifying characteristics (include pertinent clinical information such as preferred gender pronoun); **and**
 2. Results of the client's psychosocial assessment, including any diagnoses; **and**
 3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; **and**
 4. An explanation that the WPATH criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; **and**
 5. A statement about the fact that informed consent has been obtained from the patient; **and**
 6. A statement that the qualified mental health professional is available for coordination of care and how contact can be made



- Note: See ***Requirements for a Qualified Mental Health Professional** in the Indications of Coverage section
- Medication records as applicable
- Laboratory records if indicated

Disclaimer: This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may or may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

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Approved by the Medical Director