



MEDICAL COVERAGE POLICY

SERVICE: Gender Affirming Care

Policy Number:	064
Effective Date:	09/01/2023
Last Review:	07/27/2023
Next Review Date:	07/27/2024

Important note:

Unless otherwise indicated, this policy will apply to all lines of business.

Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

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PRIOR AUTHORIZATION: Required

POLICY: Not all plans cover this therapy. Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). If there is no applicable NCD or LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

Coverage for Gender affirming care varies across plans. Coverage of drugs for hormonal therapy, as well as whether the drug is covered as a medical or a pharmacy benefit, varies across plans. Please refer to the member's EOC or SPD for details.

Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:

- Behavioral health services
- Hormonal therapy
- Age-related, gender-specific services, including preventive health, as appropriate to the individual's anatomy.
- Gender reassignment and related surgery (see below).

Gender affirming care surgery may be considered medically necessary for one or more of the following:

- Reconstructive chest surgery (initial mastectomy or breast augmentation) when ALL of the following are met:
 - A letter of referral from a qualified mental health professional
 - Persistent, well-documented gender dysphoria
 - Capacity to make a fully informed decision and to consent for treatment
 - Age 18 years of age or older

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- No significant medical or mental health concerns are present OR if present, they must be reasonably well controlled
- Gonadectomy (hysterectomy and oophorectomy as appropriate) when ALL of the following are met:
 - A letter of referral from a qualified mental health professional
 - Persistent, well-documented gender dysphoria
 - Capacity to make a fully informed decision and to consent for treatment
 - Age 18 years and older
 - No significant medical or mental health concerns are present OR if present, they must be reasonably well controlled
 - Six (6) continuous months of hormone therapy as appropriate to the member's gender goals
- Genital reconstructive surgery (e.g., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male or penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female) when ALL of the following are met:
 - A letter of referral from a qualified mental health professional
 - Persistent, well-documented gender dysphoria
 - Capacity to make a fully informed decision and to consent for treatment
 - Age 18 years and older
 - No significant medical or mental health concerns are present OR if present, they must be reasonably well controlled
 - Six (6) continuous months of hormone therapy as appropriate to the member's gender goals (unless medically contraindicated)
 - Six (6) months of living in a gender role that is congruent with their gender identity (real life experience).

Procedures that may be medically necessary for gender reassignment surgery

Female to Male reconstructive genital surgery:
● Intersex surgery, female to male (may involve staged procedures to form a penis and scrotum using pedicle flaps and free-skin graft, insertion of prostheses and closure of the vagina)
● Vaginectomy/colpectomy
● Vulvectomy
● Metoidioplasty
● Phalloplasty (may include nerve transposition of medial or lateral antebrachial nerve)
● Hair removal by electrolysis of donor site tissue to be used for phalloplasty, limited to eight 30-minute timed units per day
● Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir
● Urethroplasty /urethromeatoplasty
● Hysterectomy and salpingo-oophorectomy
● Scrotoplasty

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<ul style="list-style-type: none"> • Insertion of testicular prosthesis
<ul style="list-style-type: none"> • Replacement of tissue expander with permanent prosthesis testicular insertion
<ul style="list-style-type: none"> • Testicular expanders, including replacement with prosthesis, testicular prosthesis
<ul style="list-style-type: none"> • Flaps, grafts, and/or tissue transfer directly related to a genital reconstructive procedure
<ul style="list-style-type: none"> • Initial mastectomy
<ul style="list-style-type: none"> • Nipple-areola reconstruction (related to mastectomy or post mastectomy reconstruction)
<ul style="list-style-type: none"> • Free full thickness graft (for nipple)
<ul style="list-style-type: none"> • Breast reduction
<ul style="list-style-type: none"> • Pectoral implants
<p>Male to Female reconstructive genital surgery:</p>
<ul style="list-style-type: none"> • Intersex surgery, male to female (may involve staged procedures to remove portions of male genitalia and form female external genitals such as penectomy, orchiectomy, vaginoplasty, clitoroplasty, urethroplasty, creation of a vagina)
<ul style="list-style-type: none"> • Vaginoplasty, (e.g, construction of vagina with/without graft, colovaginoplasty, penile inversion)
<ul style="list-style-type: none"> • Hair removal by electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty,
<ul style="list-style-type: none"> • Penectomy
<ul style="list-style-type: none"> • Vulvoplasty, (e.g., labiaplasty, clitoroplasty, penile skin inversion)
<ul style="list-style-type: none"> • Urethroplasty
<ul style="list-style-type: none"> • Repair of introitus
<ul style="list-style-type: none"> • Orchiectomy
<ul style="list-style-type: none"> • Flaps, grafts, and/or tissue transfer directly related to a genital reconstructive procedure
<ul style="list-style-type: none"> • Chest surgery:
<ul style="list-style-type: none"> Initial breast reconstruction including augmentation with implants
<ul style="list-style-type: none"> Fat grafting (alone, or with implant-based feminization)

The procedures listed below are considered not medically necessary for standard plans. However, some plans may cover some or all of the procedures listed below for gender dysphoria treatment. Check plan documents.

Feminization/Masculinization Procedures

- Blepharoplasty
- Brow lift

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• Cheek/malar implants
• Chin/nose implants, chin recontouring
• Collagen injections, limited to facial
• Face lift
• Forehead reduction and contouring
• Facial bone reduction (osteoplasty)
• Jaw reduction, contouring, augmentation
• Laryngoplasty
• Lip lift and lip filling
• Rhinoplasty
• Skin resurfacing (e.g., dermabrasion, chemical peels) limited to facial
• Thyroid reduction chondroplasty
• Neck tightening
• Electrolysis other than when performed pre- vaginoplasty as outlined above (i.e., face, neck) and limited to eight 30-minute timed units per day
• Suction assisted lipoplasty, lipofilling, and/or liposuction (i.e., head, neck)
• Voice therapy/voice lessons
• Voice modification surgery

BSWHP considers the following procedures that may be performed as a component of a gender affirming care as cosmetic and therefore not covered (not an all-inclusive list):

Feminization/Masculinization Procedures
• Abdominoplasty
• Calf implants
• Hair transplantation
• Suction assisted lipoplasty, lipofilling, and/or liposuction (i.e., body countouring of waist, panniculectomy, thigh, leg, hip, buttock, arm)
• Removal of redundant skin
• Neck tightening, when not part of a covered facial feminization procedure
• Lip enhancement, when not part of a covered facial feminization procedure
• Buttock lift/gluteal augmentation
• Hair removal (e.g., electrolysis), other than as noted
• Laser hair removal, for any indication

OVERVIEW: Gender refers to discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth. The condition is associated with significant distress or impairment in social, school or other important areas of functioning.

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The person manifests with the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time." Treatment in general, including surgical treatment, aims to help reduce or remove the distressing feelings of a mismatch between biological sex and gender identity.

Gender reassignment surgery, also known as transsexual surgery, sex reassignment surgery or intersex surgery, is the culmination of a series of procedures designed to change the anatomy to conform to the gender to which a person with a gender identity disorder identifies themselves. Gender reassignment surgery entails castration, penectomy and vulva-vaginal construction for male to female gender reassignment. Female to male surgery includes bilateral mastectomy, hysterectomy, salpingo-oophorectomy, followed by phalloplasty and insertion of testicular prosthesis.

MANDATES: [CFR 45 PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES](#) 156.200(e) *Non-discrimination*. A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

SUPPORTING DATA: World Professional Association for Transgender Health's (WPATH) Standards of Care—Eighth Edition as published: INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH 2022, VOL. 23, NO. S1, S1–S258

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT/HCPCS Codes for procedures that may be medically necessary	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
	11970	Replacement of tissue expander with permanent implant
	11971	Removal of tissue expander without insertion of implant
	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)
	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)
	15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
	15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
	15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
	15201	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

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15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less
15241	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15750	Flap; neurovascular pedicle
15757	Free skin flap with microvascular anastomosis
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
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53430	Urethroplasty, reconstruction of female urethra
53450	Urethromeatoplasty, with mucosal advancement
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
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
55899	Unlisted procedure, male genital system
55970	Intersex surgery; male to female
55980	Intersex surgery, female to male
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete

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	<p>56800 Plastic repair of introitus</p> <p>56805 Clitoroplasty for intersex state</p> <p>57110 Vaginectomy, complete removal of vaginal wall</p> <p>57291 Construction of artificial vagina; without graft</p> <p>57292 Construction of artificial vagina; with graft</p> <p>57335 Vaginoplasty for intersex state</p> <p>58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)</p> <p>58260 Vaginal hysterectomy, for uterus 250 g or less</p> <p>58262 Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)</p> <p>58291 Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</p> <p>58552 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</p> <p>58554 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</p> <p>58571 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</p> <p>58573 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</p> <p>58661 Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)</p> <p>58999 Unlisted procedure, female genital system (nonobstetrical)</p> <p>C1813 Prosthesis, penile, inflatable</p> <p>C2622 Prosthesis, penile, non-inflatable</p> <p>L8600 Implantable breast prosthesis, silicone or equal</p> <p>C1789 Prosthesis, breast (implantable)</p>
<p>CPT Codes for procedures that are considered NOT medically necessary for standard plans but may be explicitly covered for some plans. Check Plan documents</p>	<p>11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less</p> <p>11951 Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc</p> <p>11952 Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc</p> <p>11954 Subcutaneous injection of filling material (eg, collagen); over 10.0 cc</p> <p>15780 Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)</p> <p>15781 Dermabrasion; segmental, face</p> <p>15782 Dermabrasion; regional, other than face</p> <p>15783 Dermabrasion; superficial, any site (eg, tattoo removal)</p> <p>15786 Abrasion; single lesion (eg, keratosis, scar)</p> <p>15787 Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)</p> <p>15788 Chemical peel, facial; epidermal</p> <p>15789 Chemical peel, facial; dermal</p> <p>15792 Chemical peel, nonfacial; epidermal</p> <p>15793 Chemical peel, nonfacial; dermal</p> <p>15820 Blepharoplasty, lower eyelid</p>

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	<p>15821 Blepharoplasty, lower eyelid with extensive herniated fat pad</p> <p>15822 Blepharoplasty, upper eyelid</p> <p>15823 Blepharoplasty, upper eyelid; with excessive skin weighting down lid</p> <p>15824 Rhytidectomy, forehead</p> <p>15826 Rhytidectomy; glabellar frown lines</p> <p>15828 Rhytidectomy; cheek, chin, and neck</p> <p>15829 Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap</p> <p>15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</p> <p>15876 Suction assisted lipectomy; head and neck</p> <p>17380 Electrolysis epilation, each 30 minutes</p> <p>17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue</p> <p>21120 Genioplasty; augmentation (autograft, allograft, prosthetic material)</p> <p>21121 Genioplasty; sliding osteotomy, single piece</p> <p>21122 Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)</p> <p>21123 Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)</p> <p>21125 Augmentation, mandibular body or angle; prosthetic material</p> <p>21127 Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)</p> <p>21137 Reduction forehead; contouring only</p> <p>21138 Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)</p> <p>21139 Reduction forehead; contouring and setback of anterior frontal sinus wall</p> <p>21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)</p> <p>21179 Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)</p> <p>21180 Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)</p> <p>21188 Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)</p> <p>21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft</p> <p>21208 Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</p> <p>21209 Osteoplasty, facial bones; reduction</p> <p>21210 Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)</p> <p>21270 Malar augmentation, prosthetic material</p> <p>30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip</p> <p>30410 Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip</p> <p>30420 Rhinoplasty, primary; including major septal repair</p> <p>30430 Rhinoplasty, secondary; minor revision (small amount of nasal tip work)</p> <p>30435 Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)</p> <p>30450 Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)</p>
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	<p>31599 Unlisted procedure, larynx</p> <p>31750 Tracheoplasty; cervical</p> <p>31899 Unlisted procedure, trachea, bronchi</p> <p>40799 Unlisted procedure, lips</p> <p>67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</p> <p>92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</p>
CPT codes for procedures that are viewed as cosmetic and therefore not covered	<p>15775 Punch graft for hair transplant; 1 to 15 punch grafts</p> <p>15776 Punch graft for hair transplant; more than 15 punch grafts</p> <p>15825 Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)</p> <p>15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy</p> <p>15832 Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</p> <p>15833 Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg</p> <p>15834 Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip</p> <p>15835 Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock</p> <p>15836 Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm</p> <p>15837 Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand</p> <p>15838 Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad</p> <p>15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area wasn't crossed off on other table</p> <p>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)</p> <p>15877 Suction assisted lipectomy; trunk</p> <p>15878 Suction assisted lipectomy; upper extremity</p> <p>15879 Suction assisted lipectomy; lower extremity</p> <p>17380 Electrolysis epilation, each 30 minutes</p> <p>17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue</p> <p>40799 Unlisted procedure, lips</p>
ICD10 codes:	F64.x - Gender identity disorders Z87.890 - Personal history of sex reassignment
ICD10 Not covered:	

CMS: NCD for Transsexual Surgery. Centers for Medicare & Medicaid Services. Baltimore, Maryland. Publication Number 13-3, Manual Section Number 140.3, was nullified on May 30, 2014 (Decision 2576).

There is no Texas LCD for this service. There is an LCA A53793 from Medicare contractor Palmetto GBA.

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POLICY HISTORY:

Status	Date	Action
New	12/6/2010	New policy
Reviewed	12/6/2011	Reviewed.
Reviewed	10/25/2012	Reviewed.
Reviewed	10/3/2013	No changes
Reviewed	08/21/2014	No changes
Reviewed	04/30/2015	Added pharmacologic and consultation exclusion.
Reviewed	09/03/2015	Updated to include criteria for coverage where permitted.
Reviewed	07/07/2016	Major revision – update transgender management
Reviewed	06/13/2017	Updated “Overview” language
Reviewed	04/24/2018	No changes
Reviewed	10/31/2019	No changes
Updated	05/28/2020	Reviewed and aligned for FirstCare and SWHP
Reviewed	05/27/2021	Changed name of policy. No content change
Reviewed	04/21/2022	Reviewed. No changes. Aligned with WPATH 7 th version
Reviewed	04/27/2023	Reviewed. No changes. WPATH version 8 reviewed
Reviewed	07/27/2023	Significant changes made based on WPATH 8

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Transsexual Surgery: Its Pros and Cons. Comprehensive Exam Essay. Transsexual Women’s Resources. Medical and Other Resources for Transsexual Women (2000) <www.annelawrence.com>.Krege, S., Bex, A., et al. Male-to female transsexualism: a technique, results, results and long- term follow-up in 66 patients. *Ingentaconnect* (2001 September) 88(4): 396- 402(7).
2. Nuttbrock, L., Rosenblum, A., et al. Transgender Identity Affirmation and Mental Health. *The International Journal of Transgenderism* (2002) 6(4): 1-15.
3. Wagner, I., Fugain, C., et al. Pitch-raising surgery in fourteen male-to-female transsexuals. *Laryngoscope* (2003 July) 113(7): 1157-1165.
4. Fang, R.H., Chen, T.J., et al. Anatomic study of vaginal width in male-to-female transsexual surgery. *Plastic and Reconstructive Surgery* (2003 August) 112(2): 511- 514.
5. Hutcheson, Joel. Ambiguous genitalia and intersexuality. May 26, 2004. eMedicine Pediatric Continuing Education. (19 October 2005) <<http://www.emedicine.com>>
6. Hart, Anita C., and Catherine A. Hopkins. ICD-9-CM Professional for Physicians Volumes I & 2. Salt Lake, Utah: Ingenix (2004 October 1).
7. Rethinking the gender identity disorder terminology in the Diagnostic and Statistical Manual of Mental Disorders. – Position Paper, Bologna, Italy: HBI-GDA Conference (2005 April 7). <<http://www.avitale.com>>.
8. Kanagalingam, J., Georgalas, C., et al. Cricothyroid approximation and sublaxation in 21 male-to-female transsexuals. *Laryngoscope* (2005 April) 115(4): 611-8.
9. Sobralnske, M. Primary care needs of patients who have undergone gender reassignment. *Journal of the American Academy of Nurse Practitioners* (2005 April) 17(4): 133-138.
10. Mayer-Bahlburg, H.F. Introduction: gender dysphoria and gender change in persons with intersexuality. *Archives of Sexual Behavior* (2005 August) 34(4): 371-373.



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11. Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People. Version 7. 2012 World Professional Association for Transgender Health.
12. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health, 2022, VOL. 23, NO. S1, S1–S258.
<https://doi.org/10.1080/26895269.2022.2100644>

Note: Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plans.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs. Individual HMO plans are offered through FirstCare in West Texas.