

MN. 010.I Gender Affirming Surgery

Original Implementation Date : 11/6/2016

Version [I] Date : 12/17/2025

PARP Approved Date: 12/15/2025

Last Reviewed Date: 12/17/2025

PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans/Health Partners Plans lines of business unless noted below.

POLICY STATEMENT

COVERED

The surgical treatment of gender affirmation is considered medically necessary when **ALL** of the following criteria are met:

1. Referral from a qualified mental health professional and, in accordance with the recommendations from the World Professional Association for Transgender Health (WPATH), the referral letter must include:
 - (a) Assessment of gender identity and transgender / gender diverse (TGD).
 - (b) Availability of support from family, friends, and peers (e.g., in-person or online contact with other transsexual, transgender or gender nonconforming individuals or groups).
 - (c) Diagnosis of transgender / gender diverse (TGD) based on DSM-5 requirements.
 - (d) History and development of transgender / gender diverse (TGD) feelings.
 - (e) Impact of stigma attached to gender nonconformity on mental health.
 - (f) Psychological readiness for the requested surgeries.
2. Member demonstrates a capacity to make a fully informed decision to consent to treatment.
3. The member has been living in the gender role that is congruent with the member's gender identity for a significant period of time.

Certain surgeries are only considered medically necessary as set forth below

1. Mastectomy. Mastectomy may be considered medically necessary for female-to-male members when ALL the following criteria are met:

- (a) Assessment performed by a qualified mental health professional results in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.
- (b) Member demonstrates a capacity to make a fully informed decision to consent to treatment.
- (c) Members are 18 or older.

(Consideration will be given to members under the age 18 when: member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals (unless hormone therapy is medically contraindicated) and member has completed 12 continuous months of full-time living in a gender role that is congruent with the member's gender identity. In addition, legal guardian consent, as well as letters from two qualified mental health practitioners who have independently evaluated the member, will be required)

- (d) Significant medical or mental health concerns are optimally managed and well controlled (if present).

- (e) A referral for mastectomy from a qualified mental health professional has been provided.

2. Augmentation Mammoplasty. Augmentation Mammoplasty with implantation of breast prostheses may be considered medically necessary for male-to-female members when ALL the following criteria are met:

- (a) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

- (b) Member demonstrates a capacity to make fully informed decisions to consent to treatment.

- (c) Members are 18 or older.

(Consideration will be given to members under the age 18 when: member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals (unless hormone therapy is medically contraindicated) and member has completed 12 continuous months of full-time living in a gender role that is congruent with the member's gender identity. In addition, legal guardian consent, as well as letters from two qualified mental health practitioners who have independently evaluated the member, will be required).

- (d) Significant medical or mental health concerns are optimally managed and well controlled (if present)

- (e) A referral for augmentation mammoplasty from a qualified mental health professional has been provided.

3. Hysterectomy, Salpingectomy and/or Oophorectomy. Hysterectomy, salpingectomy and/or oophorectomy may be considered medically necessary for female-to-male members and orchiectomy may be considered medically necessary for male-to-female members when **ALL** of the following criteria are met:

- (a) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.
- (b) Member demonstrates a capacity to make a fully informed decision and can consent to treatment.
- (c) Members are 18 or older.
- (d) Significant medical or mental health concerns are optimally managed and well controlled (if present)
- (e) Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role)
- (f) Referrals for hysterectomy, salpingectomy and/or oophorectomy or orchiectomy have been provided by two qualified mental health professionals who have independently assessed the member (one of these two referrals may be from the qualified mental health professional performing the initial assessment)

4. Genital Reconstructive Surgery. Genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty with implantation of penile prosthesis and scrotoplasty with insertion of testicular implants for female-to-male members; penectomy, vaginoplasty, vulvoplasty, labiaplasty, and clitoroplasty for male-to-female members) may be considered medically necessary when **ALL** of the following criteria are met:

- (a) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.
- (b) Member demonstrates a capacity to make a fully informed decision to consent to treatment.
- (c) Members are 18 or older.
- (d) Significant medical or mental health concerns are optimally managed and well controlled (if present)
- (e) Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role).
- (f) Referrals for genital reconstructive surgery have been provided by two qualified mental health professionals who have independently assessed the member (one of these two referrals may be from the qualified mental health professional performing the initial assessment).

Gender specific services for the transgender community

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

- (a) Breast cancer screening may be medically necessary for transmasculine persons who have not undergone chest masculinization surgery.
- (b) Prostate cancer screening may be medically necessary for transfeminine people who have retained their prostate.

Procedures usually considered cosmetic (see list below) may be covered for gender affirmation when all the following criteria are met:

- (a) Member is age 18 or older.
- (b) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.
- (c) Member demonstrates a capacity to make a fully informed decision and can consent to treatment.
- (d) Significant medical or mental health concerns are optimally managed and well controlled (if present).
- (e) Referral from one qualified mental health professionals who have independently assessed the member.
- (f) Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role).
- (g) One pre-surgical evaluation by the surgeon (within 6 months of the procedure request) with the following documentation: the nature of the planned surgical procedure(s); if surgery is staged expected timetable; diagram of the specific area requiring pre-operative hair removal, if applicable etc.

List of covered procedures:

- Facial and neck reconstructive procedures (facial masculinization/ facial feminization)
- Blepharoplasty
- Cervicoplasty/ platysmaplasty
- Chin augmentation (genioplasty, mentoplasty)
- Face bone reduction
- Facial prosthesis (e.g., nasal, orbital)
- Forehead reduction
- Lip reduction/ enhancement
- Orthognathic procedures

- Rhinoplasty
- Septoplasty
- Rhytidectomy (following alteration of the underlying skeletal structures because of gender affirming facial reconstruction)
- Trachea shave/ reduction
- Thyroid chondroplasty
- Hair removal/ electrolysis when required for gender reconstructive surgery (e.g. electrolysis of free flap or other donor skin sites for breast and genital reconstructive surgery)
- Voice therapy
- Voice modification surgery (i.e., laryngoplasty, cricothyroid approximation) if needed after 12 months of hormonal therapy and voice therapy

Procedures usually considered cosmetic and not covered for gender affirmation

List of non-covered procedures:

- Body contouring procedures (e.g., abdominoplasty, suction-assisted lipectomy and lipofilling)
- Botox injections
- Calf implantation
- Chemical peels
- Collagen injections and dermal fillers (e.g., Sculptra, Radiesse)
- Dermabrasion
- Excision of redundant skin
- Gluteal augmentation (e.g., silicone implants, fat transfer, fat grafting)
- Hair reconstruction (e.g., hair removal/electrolysis, hair transplantation, wigs) except during skin preparation for gender reconstructive surgical procedures
- Mastopexy
- Monsplasty
- Nontherapeutic tattooing
- Otoplasty
- Pectoral implantation
- Skin resurfacing

Other Non-Covered Services:

1. Gender affirming surgery for members who are dissatisfied with their natal sex or prefer to be the opposite sex, without clinically significant distress or impairment resulting in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

2. Reversal of gender affirming surgery.
3. More than one breast augmentation is considered not medically necessary. This does not include the medically necessary replacement of breast implants.
4. Procedures for the preservation of fertility , including, but not limited to, the procurement, preservation, and storage of sperm, oocytes, or embryos.

POLICY GUIDELINES

In all cases, the appropriate documentation supporting medical necessity must be kept on file and, upon request, presented to us.

The definition of medical necessity may vary by product due to state and federal regulatory requirements.

The determination of medical necessity for gender affirming surgery is based on clinical data including, but not limited to, indicators that would affect the relative risks and benefits of the procedure (e.g., post-operative recovery).

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

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| CPT Code | Description |
|--------------|---|
| | |
| 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 |
| 15824 | Rhytidectomy; forehead |
| 15825 | Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) |
| 15826 | Rhytidectomy; glabellar frown lines |
| 15828 | Rhytidectomy; cheek, chin, and neck |
| 15829 | Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap |
| 17380 | Electrolysis epilation, each 30 minutes |
| 19303 | Mastectomy, simple, complete. |
| | |
| 19318 | Breast reduction |
| | |
| 19325 | Mammoplasty, augmentation; with prosthetic implant |
| 19340 | Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction |
| 19342 | Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction |
| 19350 | Nipple/areola reconstruction |
| 21120 | Genioplasty; augmentation (autograft, allograft, prosthetic material) |
| 21121 | Genioplasty; sliding osteotomy, single piece |
| 21122 | Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin) |
| 21123 | Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) |
| 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 |
| 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 (includes obtaining graft) |

| CPT Code | Description |
|--------------|---|
| 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 |
| 21208 | Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) |
| 21209 | Osteoplasty, facial bones; reduction |
| 30410 | Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip |
| 30420 | Rhinoplasty, primary; including major septal repair |
| 30430 | Rhinoplasty, secondary; minor revision (small amount of nasal tip work) |
| 30435 | Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction) |
| 30450 | Rhinoplasty, secondary; major revision (nasal tip work and osteotomies) |
| 30460 | Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only |
| 30462 | Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies |
| 30520 | Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft |
| 31592 | Cricotracheal resection |
| 31750 | Tracheoplasty; cervical |
| 31899 | Unlisted procedure, trachea, bronchi |
| 40510 | Excision of lip; transverse wedge excision with primary closure |
| 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 |
| 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 |

| CPT Code | Description |
|----------|---|
| 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 |
| 55150 | Resection of scrotum |
| 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 |
| 56800 | Plastic repair of introitus |
| 56805 | Clitoroplasty for intersex state |
| 56810 | Perineoplasty, repair of perineum, nonobstetrical |
| 57106 | Vaginectomy, partial removal of vaginal wall |
| 57107 | Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) |
| 57110 | Vaginectomy; complete removal of vaginal wall |
| 57111 | Vaginectomy; with removal of paravaginal tissue (radical vaginectomy) |
| 57291 | Construction of artificial vagina, with graft |
| 57292 | Construction of artificial vagina, without graft |
| 57295 | Revision (including removal) of prosthetic vaginal graft, vaginal approach |
| 57296 | Revision (including removal) of prosthetic vaginal graft, open 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 gms 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 |

| CPT Code | Description |
|--------------|--|
| 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 grams 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 grams; 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). |
| 58661 | Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy). |
| 58700 | Salpingectomy, complete or partial, unilateral or bilateral (separate procedure) |
| 58720 | Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) |
| 58940 | Oophorectomy, partial or total, unilateral or bilateral. |
| 58999 | Unlisted procedure, female genital system (nonobstetrical) |
| 89258 | Cryopreservation; embryo(s) |
| 89335 | Cryopreservation, reproductive tissue, testicular |
| 89337 | Cryopreservation, mature oocyte(s) |
| 89342 | Storage (per year); embryo(s) |
| 89344 | Storage (per year); reproductive tissue, testicular/ovarian |
| 89346 | Storage (per year); oocyte(s) |
| 89352 | Thawing of cryopreserved; embryo(s) |
| 89354 | Thawing of cryopreserved; reproductive tissue, testicular/ovarian |

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. All communications will specify the impacted line of business within the content of the message.

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| CPT Code | Description |
|--------------|--|
| 89398 | Unlisted reproductive medicine laboratory procedure |
| 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual |
| 92508 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals |

| HCPSC Code | Description |
|------------|--|
| S4030 | Sperm procurement and cryopreservation services; initial visit |
| S4040 | Monitoring and storage of cryopreserved embryos, per 30 days |

| ICD-10 Codes | Description |
|--------------|---------------------------------------|
| F64 | Gender identity disorders |
| F64.0 | Transsexualism |
| F64.1 | Dual role transvestism |
| F64.2 | Gender identity disorder of childhood |
| F64.8 | Other gender identity disorders |
| F64.9 | Gender identity disorder, unspecified |
| Z87.890 | Personal history of sex reassignment |

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit contract on the date the service was

rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

DESCRIPTION OF SERVICES

Gender Identity Disorder (GID), more commonly known as transsexualism, is a condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-V), published by the American Psychiatric Association. Transsexualism is also recognized in the ICD Classification of Mental and Behavioral Disorders, tenth revision, as endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as of 1994.

The criteria listed for Gender Identity Disorders (GID) including transsexualism are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity, which is developed in early childhood and understood to be firmly established by age 4, though for some transgender individuals, gender identity may remain somewhat fluid for many years. The ICD 10 descriptive criteria were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment known as transgender / gender diverse (TGD) that is often associated with transsexualism.

The World Professional Association for Transgender Health (WPATH) is an international association devoted to the understanding and treatment of individuals with gender identity disorders.

The WPATH Standards of Care for Gender Identity Disorders (Standards of Care), first issued in 1979, articulates the "professional consensus about the psychiatric, psychological, medical and surgical management of GID." Periodically revised to reflect the latest clinical practice and scientific research, the Standards also unequivocally reflect this Association's conclusion that treatment is medically necessary.

The current Board of Directors of the WPATH herewith expresses its conviction that gender affirmation, properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/or transgender / gender diverse (TGD). Gender affirmation plays an undisputed role in contributing toward favorable outcomes, and comprises Real Life Experience, legal name and sex change on identity documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures. Genital reconstruction is not required for social gender recognition, and such surgery should not be a prerequisite for document or record changes; the Real-Life Experience component of the transition process is crucial to psychological adjustment, and is usually completed prior to any genital reconstruction, when appropriate for the patient, according to WPATH Standards of Care. Changes to documentation are important aids to social functioning and are a necessary component of the pre-surgical process; delay of document changes may have a deleterious impact on a patient's social integration and personal safety.

Medically necessary gender affirming procedures also include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient (including breast

prostheses if necessary), genital reconstruction (by various techniques which must be appropriate to each patient, including, for example, skin flap hair removal, penile and testicular prostheses, as necessary), facial hair removal, and certain facial plastic reconstruction (as appropriate to the patient).

Furthermore, not every patient will have a medical need for identical procedures; clinically appropriate treatments must be determined on an individualized basis with the patient's physician.

The medical procedures attendant to gender affirmation are not "cosmetic" or "elective" or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense but are understood to be medically necessary for the treatment of the diagnosed condition. Further, the WPATH Standards of Care consider it unethical to deny eligibility for gender affirming surgeries or hormonal therapies solely on the basis of blood seropositivity for infections such as HIV or hepatitis.

These medical procedures and treatment protocols are not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient. For example, a recent study of female-to-male transsexuals found significantly improved quality of life following cross-gender hormonal therapy. Moreover, those who had also undergone chest reconstruction had significantly higher scores for general health, social functioning, as well as mental health.

The WPATH Board of Directors urges state healthcare providers and insurers throughout the world to eliminate transgender or trans-sex exclusions and to provide coverage for transgender patients including the medically prescribed gender affirming services necessary for their treatment and well-being, and to ensure that their ongoing healthcare (both routine and specialized) is readily accessible.

CLINICAL EVIDENCE

N/A

DEFINITIONS

GENDER AFFIRMING SURGERY

Gender affirming surgery is the surgical procedure (or procedures) by which a transgender person's physical appearance and function of their existing sexual characteristics are altered to resemble that socially associated with their identified gender. It is part of a treatment for transgender / gender diverse (TGD) in transgender people.

Transgender / Gender Diverse (TGD) Transgender / gender diverse (TGD): (1) Discontent with the physical or social aspects of one's own sex. (2) In *DSM-5*, a diagnostic class that replaces gender identity disorder and shifts clinical emphasis from cross-gender identification itself to a focus on the possible distress arising from a sense of mismatch, or incongruence, that one may have about one's experienced gender versus one's assigned gender. Diagnostic criteria for transgender / gender diverse (TGD) in children include significant distress or impairment due to marked gender incongruence, such as a strong desire to be-or a belief that one is-the other gender; preference for the toys, games, roles, and activities stereotypically associated with the other gender, and a strong dislike of one's sexual anatomy. In adults, the manifestations of transgender / gender diverse (TGD) may include a strong desire to replace one's physical sex characteristics with those of the other gender (see *SEX REASSIGNMENT*), the belief that one has the emotions of their gender, and a desire to be treated as the other gender or recognized as having an alternative gender identity.

QUALIFIED MENTAL HEALTH PROFESSIONAL

Qualified Mental Health Professional: A mental health professional who diagnoses and treats adults presenting for care regarding their gender identity or transgender / gender diverse (TGD) and who possess the following minimum credentials, as recommended in the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7:1

- 1) A master's degree or equivalent in a clinical behavioral science field from an institution accredited by the appropriate national accrediting board and is licensed by the relevant licensing board to practice in the Commonwealth of Pennsylvania.
- 2) Competence in using the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders for diagnostic purposes.
- 3) Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from transgender / gender diverse (TGD). Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of transgender / gender diverse (TGD)
- 4) Documented supervised training and competence in psychotherapy or counseling.
- 5) Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of transgender / gender diverse (TGD).
- 6) Continuing education in the assessment and treatment of transgender / gender diverse (TGD). 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 transgender / gender diverse (TGD).

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

For Health Partners Plans Medicaid and Health Partners Plans Chip products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

| Summary | Version | Version Date |
|---|---------|--------------|
| 2025 Annual Review. Revisions to terminology, Policy Statement and Coding sections. References updated. | I | 12/17/2025 |
| October 2024 ad-hoc review. Coverage criteria revised. | H | 12/18/2024 |
| July 2024 ad-hoc review. Product variation section updated to include coverage for all lines of business. | G | 07/19/2024 |
| 2024 Annual review. CPT code 19318 (Breast reduction) was added to the coding table. | F | 05/15/2024 |
| 2023 Annual review. Minor change. Nipple reconstruction removed from non-covered section. | E | 05/01/2022 |
| 2022 Annual review. Added to covered services: Gender specific services for the transgender community. Added to non-covered services: More than one breast augmentation | E | 05/01/2022 |
| 2021 Annual review. The following was added to the non-covered section of the policy: facial feminization surgery, masculinization surgery, procedures for the preservation of fertility. The following codes were added to the coding table: 89258, 89335, 89337, 89342, 89344, 89346, 89352, 89354, 89398, S4030 & S4040. | D | 07/01/2021 |
| 2020 Annual review. Language was added to the policy statement to enhance readability. | C | 09/01/2020 |
| 2019 Annual review. No revisions to this version. | B | 07/18/2018 |
| 2018- Modifications made to enhance readability and clarify intent, including addition of definitions. New codes added. | B | 07/18/2018 |
| New policy. | A | 11/06/2016 |

REFERENCES

- 1) The World Professional Association for Transgender Health (WPATH). Standards of Care <https://wpath.org/publications/soc8/chapters/>
- 2) The World Professional Association for Transgender Health (WPATH) <https://wpath.org/wp-content/uploads/2024/11/WPATH-Position-on-Medical-Necessity-12-2016.pdf>
- 3) American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, Fifth Edition, Arlington, Virginia: American Psychiatric Association.
- 4) Monstrey S., G. De Cuypere, and R. Ettner. 2007. "Surgery: General Principles." In *Principles of Transgender Medicine and Surgery*, edited by Randi Ettner, Stan Monstrey, and Eli Coleman, 90. New York: Haworth Press.
- 5) Newfield, Emily, Stacey Hart, Suzanne Dibble, and Lori Kohler. 2006. "Female-to-Male Transgender Quality of Life." *Quality of Life Research* 15 (9): 1147–57.
- 6) Pfäfflin, Freidemann, and Astrid Junge. 1998. *Sex Reassignment: Thirty Years of International Follow-up Studies after Sex Reassignment Surgery: A Comprehensive Review, 1961–1991*. Translated by Roberta B. Jacobson and Alf B. Meier. Düsseldorf, Germany: Symposion.
- 7) Mass.gov. "Guidelines for Medical Necessity Determination for Gender Reassignment Surgery." <https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-gender-affirming-surgery> .
- 8) Centers for Medicare & Medicaid Services (CMS). *National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9)*. <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=368&ncdver=1&DocID=140.9&bc=gAAAABAAAA&>
- 9) Guidelines for Medical Necessity Determination for Gender Reassignment Surgery. MassHealth. <https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-gender-affirming-surgery>
- 10) Wikipedia (Gender confirmation surgery definition): https://en.wikipedia.org/wiki/Sex_reassignment_surgery
- 11) 2018 American Psychological Association (Gender Dysphoria definition): <https://www.apa.org/monitor/2018/09/ce-corner-glossary>