Clinical UM Guideline

Subject: Gender Affirming Surgery
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Description

This document addresses gender affirming surgery (also known as sex affirmation surgery, gender or sex reassignment surgery, gender or sex confirmation surgery). Gender affirming surgery is a treatment option for gender dysphoria, a condition in which a person experiences persistent incongruence between gender identity and sexual anatomy at birth. Gender affirming surgery is not an isolated intervention; it is part of a complex process involving multiple medical, psychiatric and psychologic, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes.

Note: Please refer to the following documents for additional information, including the use of these and other procedures for individuals with gender dysphoria that *are not related to gender affirming surgery*:

- ANC.00007 Cosmetic and Reconstructive Services: Skin Related
- ANC.00008 Cosmetic and Reconstructive Services of the Head and Neck
- ANC.00009 Cosmetic and Reconstructive Services of the Trunk and Groin
- CG-SURG-03 Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- CG-SURG-12 Penile Prosthesis Implantation
- SURG.00023 Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- TRANS.00037 Uterine Transplantation

Note: Voice therapy is not addressed in this document, as it is not a surgical procedure.

Medically Necessary: In this document, procedures are considered medically necessary if there is a significant functional impairment AND the procedure can be reasonably expected to improve the functional impairment.

Reconstructive: In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or a congenital defect.

Note: Not all benefit contracts/certificates include benefits for reconstructive services as defined by this document. Benefit language supersedes this document.

Cosmetic: In this document, procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those that are primarily intended to preserve or improve appearance.

Clinical Indications

NOTE: Procedures to address postoperative complications of gender affirming surgery procedures (for example, stenosis, scarring, chronic infection, or pain) are not considered separate gender affirming surgery procedures.

NOTE: Reversal of a prior gender affirming surgery procedure is considered gender affirming surgery and the medical necessity criteria below apply.

Medically Necessary:

Gender affirming pelvic or gonadal surgery (which may consist of a combination of the following: *hysterectomy, orchiectomy*, *ovariectomy, or salpingo-oophorectomy*), is considered **medically necessary** when *all* of the following

criteria are met:

A. The individual is at least 18 years of age; **and**
B. The individual has capacity to make fully informed decisions and consent for treatment; **and**
C. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**
D. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; **and**
E. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**
F. Two referrals from qualified mental health professionals* who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required. The letter(s) must have been signed within 12 months of the request submission.

Gender affirming genital surgery (which may consist of a combination of the following: *clitoroplasty, labiaplasty, metoidioplasty, penectomy, phalloplasty, scrotoplasty, urethroplasty, vaginectomy, vaginoplasty, or placement of penile or testicular prostheses*), is considered **medically necessary** when *all* of the following criteria are met:

A. The individual is at least 18 years of age; **and**
B. The individual has capacity to make fully informed decisions and consent for treatment; **and**
C. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**
D. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; **and**
E. Documentation** that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in the new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings); **and**
F. Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; **and**
G. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**
H. Two referrals from qualified mental health professionals* who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required. The letter(s) must have been signed within 12 months of the request submission.

*At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) or a master's level degree in a clinical behavioral science field (for example, M.S.W., L.C.S.W., Nurse Practitioner [N.P.], Advanced Practice Nurse [A.P.R.N.], Licensed Professional Counselor [L.P.C.], and Marriage and Family Therapist [M.F.T.]) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the specifications set forth above.

**The medical documentation should include the start date of living full time in the new gender. Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases.

The use of hair removal procedures to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure is considered **medically necessary.**

Reconstructive

Gender affirming chest surgery (*augmentation, mastectomy, or reduction*) is considered **reconstructive** when *all* of the following criteria have been met:

A. The individual is at least 18 years of age (see *Further Considerations* section below for individuals under 18 years of age); **and**
B. The individual has capacity to make fully informed decisions and consent for treatment; **and**
C. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**
D. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**
E. *For gender affirming breast augmentation procedures only*: for individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician, and insufficient breast development has occurred; **and**
F. Existing chest appearance demonstrates significant variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); **and**
G. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

Nipple reconstruction, including tattooing, following a gender affirming mastectomy that meets the reconstructive criteria above is considered **reconstructive.**

Gender affirming facial surgery† is considered **reconstructive** when *all* of the following criteria have been met:

A. The individual is at least 18 years of age; **and**
B. The individual has capacity to make fully informed decisions and consent for treatment; **and**
C. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**
D. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; **and**
E. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**
F. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; **and**
G. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); **and**
H. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

†See Discussion section for a list of procedures included in this group of procedures.

Gender affirming voice modification surgery is considered **reconstructive** when *all* of the following criteria have been met:

A. The individual is at least 18 years of age; **and**
B. The individual has capacity to make fully informed decisions and consent for treatment; **and**
C. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**
D. *For gender masculinization only:* for individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; **and**
E. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic

episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**

F. Existing vocal presentation demonstrates significant variation from normal for the experienced gender; **and**
G. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

Not Medically Necessary:

The following gender affirming surgical procedures are considered **not medically necessary** *when one or more of the medical necessary or reconstructive criteria above have not been met*:

A. Clitoroplasty
B. Hysterectomy
C. Labiaplasty
D. Metoidioplasty
E. Orchiectomy
F. Ovariectomy
G. Penectomy
H. Phalloplasty
I. Placement of penile or testicular prostheses
J. Salpingo-Oophorectomy
K. Scrotoplasty
L. Urethroplasty
M. Vaginectomy
N. Vaginoplasty

Cosmetic and Not Medically Necessary:

The following procedures, when requested alone or in combination with other procedures, are considered **cosmetic and not medically necessary** when applicable reconstructive criteria above have not been met, or when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender affirming surgery, including, but not limited to, the following:

A. Abdominoplasty
B. Bilateral mastectomy
C. Blepharoplasty
D. Breast augmentation
E. Brow lift
F. Calf implants
G. Face lift
H. Facial bone reconstruction
I. Facial implants
J. Gluteal augmentation
K. Hair removal (for example, electrolysis or laser) and hairplasty, when the criteria above have not been met
L. Jaw reduction (jaw contouring)
M. Lip reduction/enhancement
N. Lipofilling/collagen injections
O. Liposuction
P. Nose implants
Q. Pectoral implants
R. Rhinoplasty
S. Thyroid cartilage reduction (chondroplasty)
T. Voice modification surgery

Further Considerations:

A provider with experience treating adolescents with gender dysphoria may request further consideration of a gender affirming chest procedure case in an individual under 18 years old when they meet all other gender affirming chest procedure criteria above (including prior mental health evaluation) by contacting a Medical Director. *(Further information is*

available in the Discussion/General Information section of this document titled 'Gender Affirming Surgery in Individuals Under the Age of 18').

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT	
17380	Electrolysis epilation, each 30 minutes [when done to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure]
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue [when specified as permanent hair removal by laser to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure]
53410	Urethroplasty, 1-stage reconstruction of male anterior 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
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy
55180	Scrotoplasty; complicated
55899	Unlisted procedure, male genital system [when specified as metoidioplasty or phalloplasty with penile prosthesis]
56625	Vulvectomy, simple; complete
56800	Plastic repair of introitus
57110	Vaginectomy, complete removal of vaginal wall;
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
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);
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
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)

HCPCS	
C1813	Prosthesis, penile, inflatable

C2622	Prosthesis, penile, non-inflatable
L8699	Prosthetic implant, not otherwise specified [when specified as testicular or penile prosthesis]

ICD-10 Procedure

0HDSXZZ	Extraction of hair, external approach [when done to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure]
0UQG0ZZ	Repair vagina, open approach
0UQJ0ZZ-0UQJXZZ	Repair clitoris [by approach; includes codes 0UQJ0ZZ, 0UQJXZZ]
0UT20ZZ-0UT2FZZ	Resection of bilateral ovaries [by approach; includes codes 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ]
0UT70ZZ-0UT7FZZ	Resection of bilateral fallopian tubes [by approach; includes codes 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ]
0UT90ZZ-0UT9FZZ	Resection of uterus [by approach; includes codes 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ]
0UTC0ZZ-0UTC8ZZ	Resection of cervix [by approach; includes codes 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ]
0UTG0ZZ-0UTG8ZZ	Resection of vagina [by approach; includes codes 0UTG0ZZ, 0UTG4ZZ, 0UTG7ZZ, 0UTG8ZZ]
0UTJ0ZZ-0UTJXZZ	Resection of clitoris [by approach; includes codes 0UTJ0ZZ, 0UTJXZZ]
0UTM0ZZ-0UTMXZZ	Resection of vulva [by approach; includes codes 0UTM0ZZ, 0UTMXZZ]
0VRC0JZ	Replacement of bilateral testes with synthetic substitute, open approach
0VTC0ZZ-0VTC4ZZ	Resection of bilateral testes [by approach; includes codes 0VTC0ZZ, 0VTC4ZZ]
0VTS0ZZ-0VTSXZZ	Resection of penis [by approach; includes codes 0VTS0ZZ, 0VTS4ZZ, 0VTSXZZ]
0VUS07Z-0VUSX7Z	Supplement penis with autologous tissue substitute [by approach, includes codes 0VUS07Z, 0VUS47Z, 0VUSX7Z]
0VUS0JZ-0VUSXJZ	Supplement penis with synthetic substitute [by approach; includes codes 0VUS0JZ, 0VUS4JZ, 0VUSXJZ]
0VUS0KZ-0VUSXKZ	Supplement penis with nonautologous tissue substitute [by approach; includes codes 0VUS0KZ, 0VUS4KZ, 0VUSXKZ]
0W4M070	Creation of vagina in male perineum with autologous tissue substitute, open approach
0W4M0J0	Creation of vagina in male perineum with synthetic substitute, open approach
0W4M0K0	Creation of vagina in male perineum with nonautologous tissue substitute, open approach
0W4N071	Creation of penis in female perineum with autologous tissue substitute, open approach
0W4N0J1	Creation of penis in female perineum with synthetic substitute, open approach
0W4N0K1	Creation of penis in female perineum with nonautologous tissue substitute, open approach

ICD-10 Diagnosis

F64.0-F64.9	Gender identity disorders
Z87.890	Personal history of sex reassignment

When services are Not Medically Necessary:
For the procedure and diagnosis codes listed above when criteria are not met.

When services may be Reconstructive when criteria are met:

CPT

11920-11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less [when specified for nipple/areola reconstruction after breast surgery; includes codes 11920, 11921, 11922]
11950-11954	Subcutaneous injection of filling material (eg, collagen) [includes codes 11950, 11951, 11952, 11954]
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
15771-15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs
15773-15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet
15876	Suction assisted lipectomy, head and neck
15877	Suction assisted lipectomy, trunk [when specified as breast liposuction for breast reduction]
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue [when specified as injection of a dermal soft tissue filler]

19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
21120-21123	Genioplasty [includes codes 21120, 21121, 21122, 21123]
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137-21139	Reduction forehead [includes codes 21137, 21138, 21139]
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21193-21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy [with or without bone graft]
21195-21196	Reconstruction of mandibular rami and/or body, sagittal split [with or without internal rigid fixation]
21198	Osteotomy, mandible, segmental
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	Graft, bone; mandible (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400-30420	Rhinoplasty, primary [includes codes 30400, 30410, 30420]
30430-30450	Rhinoplasty, secondary [includes codes 30430, 30435, 30450]
31599	Unlisted procedure, larynx [when specified as thyroid cartilage chondroplasty, tracheal shave, or voice modification surgery such as anterior glottal web formation, cricothyroid approximation, vocal cord shortening]

HCPCS

L8600	Implantable breast prosthesis, silicone or equal
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg

ICD-10 Procedure

0H0V07Z-0H0V0KZ	Alteration of bilateral breast, open approach; [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0H0V07Z, 0H0V0JZ, 0H0V0KZ]
0HBV0ZZ-0HBV8ZZ	Excision of breast, bilateral [by approach; includes codes 0HBV0ZZ, 0HBV3ZZ, 0HBV7ZZ, 0HBV8ZZ]
0HRW07Z-0HRXXKZ	Replacement of nipple [by approach; includes codes 0HRW07Z, 0HRW0JZ, 0HRW0KZ, 0HRW3JZ, 0HRW3KZ, 0HRW37Z, 0HRWX7Z, 0HRWXJZ, 0HRWXKZ, 0HRX07Z, 0HRX0JZ, 0HRX0KZ, 0HRX3JZ, 0HRX3KZ, 0HRX37Z, 0HRXX7Z, 0HRXXJZ, 0HRXXKZ]
0NB10ZZ	Excision of frontal bone, open approach
0NBB0ZZ	Excision of nasal bone, open approach
0NBM0ZZ	Excision of right zygomatic bone, open approach
0NBN0ZZ	Excision of left zygomatic bone, open approach
0NBR0ZZ	Excision of maxilla, open approach
0NBT0ZZ	Excision of right mandible, open approach
0NBV0ZZ	Excision of left mandible, open approach
0NU107Z-0NU10KZ	Supplement frontal bone, open approach; [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0NU107Z, 0NU10JZ, 0NU10KZ]
0NUB07Z-0NUB0KZ	Supplement nasal bone, open approach; [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0NUB07Z, 0NUB0JZ, 0NUB0KZ]

0NUM07Z-0NUN0KZ	Supplement zygomatic bone, open approach; [right or left, with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0NUM07Z, 0NUM0JZ, 0NUM0KZ, 0NUN07Z, 0NUN0JZ, 0NUN0KZ]
0NUR07Z-0NUR0KZ	Supplement maxilla, open approach; [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0NUR07Z, 0NUR0JZ, 0NUR0KZ]
0NUT07Z-0NUV0KZ	Supplement mandible, open approach; [right or left, with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0NUT07Z, 0NUT0JZ, 0NUT0KZ, 0NUV07Z, 0NUV0JZ, 0NUV0KZ]
0W0407Z-0W040KZ	Alteration of upper jaw, open approach [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0W0407Z, 0W040JZ, 0W040KZ]
0W040ZZ	Alteration of upper jaw, open approach
0W0507Z-0W050KZ	Alteration of lower jaw, open approach [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0W0507Z, 0W050JZ, 0W050KZ]
0W050ZZ	Alteration of lower jaw, open approach
0WU407Z-0WU40KZ	Supplement lower jaw, open approach [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0WU407Z, 0WU40JZ, 0WU40KZ]
0WU507Z-0WU50KZ	Supplement lower jaw, open approach [with autologous tissue substitute, synthetic substitute, or nonautologous tissue substitute; includes codes 0WU507Z, 0WU50JZ, 0WU50KZ]

ICD-10 Diagnosis

F64.0-F64.9	Gender identity disorders
Z87.890	Personal history of sex reassignment

When services are Cosmetic and Not Medically Necessary:
For the procedure and diagnosis codes listed above when reconstructive criteria are not met or when the code describes a procedure designated in the Clinical Indications section as cosmetic and not medically necessary.

Discussion/General Information (Return to Clinical Indications)

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-5-TR) provides criteria for the diagnosis of gender dysphoria. The DSM-5-TR criteria are widely recognized as the community standard by which individuals with suspected gender dysphoria are evaluated. The DSM-5-TR criteria for gender dysphoria are as follows:

Gender dysphoria in Children*

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):
    1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
    2. In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
    3. A strong preference for cross-gender roles in make-believe play or fantasy play.
    4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
    5. A strong preference for playmates of the other gender.
    6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    7. A strong dislike of one's sexual anatomy.
    8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

    Specify if:
    With a disorder/difference of sex development (e.g., a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome)
    Coding note: Code the disorder/difference r of sex development as well as gender dysphoria.

Gender dysphoria in Adolescents and Adults*

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).
    2. 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).
    3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
    4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    6. 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).
B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

    Specify if:
    With a disorder/difference of sex development (e.g., a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome)
    Coding note: Code the disorder/difference of sex development as well as gender dysphoria.

    Specify if:
    Post transition: The individual has transitioned to full-time living in the experienced gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one gender affirming medical procedure or treatment regimen- namely regular gender affirming hormone treatment or gender reassignment surgery confirming the experienced gender (e.g., breast augmentation surgery and/or, vulvovaginoplasty in an individual assigned male at birth; transmasculine chest surgery and/or phalloplasty or metoidioplasty in an individual assigned female at birth).

*From: American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision. February 2022. Washington, DC. Pages 511-520.

The World Professional Association for Transgender Health's (WPATH) Standards of Care (SOC) for the Health of Transgender and Gender Diverse People, 8th Version (2022) (SOC8) provides the most recent recommendations for care of transgender and gender diverse (TGD) individuals. The SOC8 states,

> The SOC-8 guidelines are intended to be flexible in order to meet the diverse health care needs of TGD people globally. While adaptable, they offer standards for promoting optimal health care and for guiding the treatment of people experiencing gender incongruence.
>
> and
>
> Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies.

In the WPATH SOC8 references the World Health Organization's International Classification of Diseases (ICD)-11 as the appropriate criteria to establish the presence or absence of gender incongruence. It must be noted that the ICD-11 is not widely used in the U.S. for diagnostic purposes. The generally accepted reference used by providers in the U.S. for the diagnosis of psychiatric and phycological conditions is the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), version 5 text revision (DSM-5-TR). As such, the DSM-5-TR criteria are used in this document in lieu of the ICD-11. It should also be noted that the WPATH SOC8 have been created for a global audience and intended for use across a wide variety of cultures and healthcare systems. With that in mind, some recommendations should be re-assessed in the context of U.S.-based medical and surgical settings.

Any variations from recommendations by WPATH within this guideline may reflect where SOC standards are, for example, not based on published medical evidence.

Hormone Therapy

While this document does not address the medical necessity of gender-affirming hormone therapy (GAHT), GAHT plays an important role in the gender transition process by altering body hair, breast size or development, skin appearance and texture, body fat distribution, the size and function of sex organs, and other characteristics, including voice deepening. Use of GAHT prior to some surgical procedures has been identified as an important factor in improved functional, cosmetic, and psychological outcomes and this should be taken into serious consideration prior to any surgical procedures. GAHT should be administered under medical supervision. The WPATH SOC8 guidelines is supportive of this approach, stating the following:

> GAHT leads to anatomical, physiological, and psychological changes. The onset of the anatomic effects (e.g., clitoral growth, vaginal mucosal atrophy) may begin early after the initiation of therapy, and the peak effect is expected at 1–2 years (T'Sjoen et al., 2019). Depending upon the surgical result required, a period of hormone treatment may be required (e.g., sufficient clitoral virilization prior to metoidioplasty/phalloplasty) or preferred for psychological reasons, anatomical reasons, or both (breast growth and skin expansion prior to breast augmentation, softening of skin and changes in facial fat distribution prior to facial GAS) (de Blok et al., 2021).
>
> For individuals who are not taking hormones prior to surgical interventions, it is important surgeons review the impact of this on the proposed surgery.

The optimal duration of hormone therapy prior to a surgical procedure has not been the subject of extensive, rigorous study. However, existing evidence indicates that the maximum physiological effects are usually reached at 1-2 years, but may take longer. For individuals without a medical contraindication or intolerance, a minimum of 12 months of continuous GAHT, when clinically recommended, is likely to improve outcomes before some surgical procedures.

Introduction to Surgical Procedures

The criteria sets provided above in the Clinical Indications section include several shared criterion applicable to the decision making process for the majority of situations where an individual may be seeking gender affirming surgical procedures, including the following:

A. The individual is at least 18 years of age
B. The individual has capacity to make fully informed decisions and consent for treatment
C. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria)
D. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated

The age of 18 is the "age of majority" in the U.S. and is considered the age at which an individual is recognized as an adult and assumes specific rights and responsibilities. An individual seeking gender affirming surgical procedures should have established sufficient cognitive and physical maturity to make important decisions related to self-determination, including medical decisions.

The capacity to make fully informed decisions and consent for treatment is an important consideration for individuals seeking gender affirming care, especially when medical and surgical decisions have the potential for serious long-term impact on an individual's physical, psychological, reproductive, and social function. Capacity for consent includes several factors, including the ability to understand the nature of the treatment options, the ability to reason through the risks and benefits of their treatment options, the ability to understand and appreciate the potential long-term ramifications of their decisions, and the ability to effectively communicate their choices. These attributes are especially important in the realm of gender affirming surgical procedures, given the serious risks and long-term impacts they have. The issue of capacity to consent in adolescents is addressed in the applicable section below.

Establishing an accurate diagnosis of gender dysphoria is important to help ensure that the procedures requested are appropriate to the individual's medical needs. As noted above, a diagnosis of gender dysphoria using DSM-5-TR criteria is considered in accordance with generally accepted standards of medical practice. Additionally, assessment should consider and exclude the likelihood that an individual's gender-related symptoms are the result of other causes that are unlikely to respond to gender affirming treatment, including psychosis, neurodiversity, and/or suppressed homosexuality. Recent scientific evidence has pointed to other important factors that may impact gender identity decisions, including peer interactions and exposure to social and other media. Given the complexity of the evaluation process, a multidisciplinary

approach to the evaluation and management of an individual seeking gender affirming surgical treatment is considered in accordance with generally accepted standards of medical practice.

Management of co-morbid psychological conditions, including depression or anxiety, as well as self-harm, can have a significant impact on the successful outcome of gender affirming surgical procedures (particularly when the primary indication for surgery is psychological distress or incongruity). Similarly, adequate control of co-morbid medical conditions, such as endocrine or autoimmune disorders, is important to increase the likelihood of successful surgical and psychological outcomes.

The WPATH SOC8 provides the following recommendations below for the treatment of adults requesting surgical treatment for gender dysphoria, which are conceptually aligned with criteria provided above in the Clinical Indications section.

For Adults: The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (all should be met):

5.3- We recommend health care professionals assessing transgender and gender diverse adults for gender-affirming medical and surgical treatment:
5.3.a- Only recommend gender-affirming medical treatment requested by a TGD person when the experience of gender incongruence is marked and sustained.
5.3.b- Ensure fulfillment of diagnostic criteria prior to initiating gender-affirming treatments in regions where a diagnosis is necessary to access health care.
5.3.c- Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.
5.3.d- Ensure that any mental health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
5.3.e- Ensure any physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
5.3.f- Assess the capacity to consent for the specific physical treatment prior to the initiation of this treatment.
5.3.g- Assess the capacity of the gender diverse and transgender adult to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming treatment.
5.4- We suggest, as part of the assessment for gender-affirming hormonal or surgical treatment, professionals who have competencies in the assessment of transgender and gender diverse people wishing gender-related medical treatment consider the role of social transition together with the individual.
5.5- We recommend transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment.
5.6- We suggest health care professionals assessing transgender and gender diverse people seeking gonadectomy consider a minimum of 6 months of hormone therapy as appropriate to the TGD person’s gender goals before the TGD person undergoes irreversible surgical intervention (unless hormones are not clinically indicated for the individual).
5.7- We recommend health care professionals assessing adults who wish to detransition and seek gender-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professional in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process.

Criteria for surgery

a. Gender incongruence is marked and sustained;
b. Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access health care;
c. Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
d. Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options;
e. Other possible causes of apparent gender incongruence have been identified and excluded;

f. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed;
g. Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).*
*These were graded as suggested criteria

The WPATH SOC8 also include the following recommendations that they state for adults and adolescents:

13.2- We recommend surgeons assess transgender and gender diverse people for risk factors associated with breast cancer prior to breast augmentation or mastectomy.
13.3- We recommend surgeons inform transgender and gender diverse people undergoing gender-affirming surgical procedures about aftercare requirements, travel and accommodations, and the importance of postoperative follow-up during the preoperative process.
13.4- We recommend surgeons confirm reproductive options have been discussed prior to gonadectomy in transgender and gender diverse people.
13.5- We suggest surgeons consider offering gonadectomy to eligible* transgender and gender diverse adults when there is evidence they have tolerated a minimum of 6 months of hormone therapy (unless hormone replacement therapy or gonadal suppression is not clinically indicated or the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity).
13.6- We suggest health care professionals consider gender-affirming genital procedures for eligible* transgender and gender diverse adults seeking these interventions when there is evidence the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).
13.7- We recommend surgeons consider gender-affirming surgical interventions for eligible* transgender and gender diverse adolescents when there is evidence a multidisciplinary approach that includes mental health and medical professionals has been involved in the decision-making process.
13.8- We recommend surgeons consult a comprehensive, multidisciplinary team of professionals in the field of transgender health when eligible* transgender and gender diverse people request individually customized (previously termed “non-standard”) surgeries as part of a gender-affirming surgical intervention.
13.9- We suggest surgeons caring for transgender men and gender diverse people who have undergone metoidioplasty/phalloplasty encourage lifelong urological follow-up.
13.10- We recommend surgeons caring for transgender women and gender diverse people who have undergone vaginoplasty encourage follow-up with their primary surgeon, primary care physician, or gynecologist.
13.11- We recommend patients who regret their gender-related surgical intervention be managed by an expert multidisciplinary team.

Criteria in the Clinical Indications sections above that are procedure-specific are addressed below.

Chronicity/Timing of Surgical Procedures

Procedures for the chest, groin, and reproductive organs may not need to be done in conjunction with other procedures. 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 as required for treatment for gender dysphoria. Furthermore, some surgical procedures may be done in stages with significant time delays between staged procedures. For purposes of this document, these series of procedures should be considered as a single procedure.

Gender Affirming Pelvic and Gonadal Procedures

Procedures addressing pelvic and gonadal anatomy (for example; hysterectomy, orchiectomy, ovariectomy, or salpingo-oophorectomy) in individuals with gender dysphoria are conducted to achieve the experienced physical anatomy and function aligning with the individual’s experienced gender. Gender affirming pelvic and gonadal procedures have been shown in many studies to provide significant functional improvement in multiple areas (Almazan, 2021; Becker, 2018; Butler, 2019; Cardoso da Silva, 2016; Castellano, 2015; De Cuypere, 2005; de Vries, 2014; Djordjevic, 2009; Guss, 2015; Hage, 2006; Jellestad, 2018; Lawrence, 2006; Miller, 2019; Murad, 2010; Olson-Kennedy, 2018; Owen-Smith, 2018; Papadopulos, 2015; Simbar, 2018; Terrier, 2014; Tucker, 2018; van de Grift, 2017; Weigert, 2013; Wernick, 2019; Wierckx, 2011). These improvements include gender dysphoria-related symptoms such as psychological distress, depression, anxiety, and

acceptance of the individual's body. Additionally, the available literature also demonstrates significant benefits related to quality of life and overall well-being.

The medical necessity criteria above for pelvic and gonadal procedures are based on several sources, including the WPATH SOC8, published peer-reviewed studies, and expert opinion. Gonadal and pelvic gender affirming surgical procedures present significant medical and psychological risks, and the results are irreversible (Djordjevic, 2016). The risk of these procedures should be discussed with any individual seeking gonadal and pelvic gender affirming surgical procedures.

Gender Affirming Genital Procedures

Gender affirming surgical procedures addressing genital anatomy (for example, clitoroplasty, labiaplasty, metoidioplasty, penectomy, phalloplasty, scrotoplasty, urethroplasty, vaginectomy, vaginoplasty/colovaginoplasty/ coloproctostomy, or placement of penile or testicular prostheses) involve complex surgical techniques and present significant risk of surgical and medical complications. Before an individual undergoes these types of procedures, a thorough, multidisciplinary decision-making process should be utilized, one that involves adequate attempts at optimal hormonal therapy as well as successful completion of real-life experience in the experienced gender of the individual.

Published peer-reviewed studies have shown that hormonal and psychological therapy and real-life experience living as the other gender, as well as social support and acceptance by peer and family groups, improve psychological outcomes in individuals undergoing gender affirming surgery (Eldh, 1997; Landen, 1998). Monstrey (2001) described the importance of close cooperation between the medical and behavioral specialties required for proper treatment of individuals with gender dysphoria who wish to undergo gender affirming surgery. Similar findings were reported earlier by Schlatterer (1996). One study of 188 subjects undergoing gender affirming surgery found that dissatisfaction with surgery was highly associated with sexual preference, psychological co-morbidity, and poor pre-operative body image and satisfaction (Smith, 2005).

Hair removal Procedures

In many instances, the creation of a neovagina or a urethra for a neopenis requires an autologous skin graft from the forearm or thigh. Such skin may have hair present, which will impair the successful function of the newly constructed organ if not permanently removed. Pre-operative permanent hair removal treatments to these areas may be warranted to prevent post-operative complications.

Gender Affirming Chest Surgery:

Gender affirming chest surgery in individuals with gender dysphoria is reconstructive, in that the procedure is intended to address the significant variation from normal appearance for the experienced gender. The evidence addressing gender affirming chest surgery for the treatment of gender dysphoria supports a consistent association between surgery and satisfaction with breast appearance, psychological and sexual well-being, and body image and attractiveness; however, evidence supporting improvements in functional outcomes (for example, quality of life, gender dysphoria symptoms, or sequelae of severe illness, including crisis visits, suicide attempts, etc.) is less clear (Almazan, 2021; Becker, 2018; Miller, 2019; Olson-Kennedy, 2018; Weigert, 2013). Criteria for chest surgery are generally consistent with other gender affirming surgical procedures, including requirements related to age, capacity to consent, diagnosis of gender dysphoria, and reasonably well controlled concomitant physical and mental health conditions.

Criteria requiring hormone therapy for individuals assigned as male at birth (unless there is a medical contraindication or documented intolerance) aims to allow the development of at least some breast tissue prior to the desired surgery. As noted above in the section addressing GAHT, the use of hormone therapy has been shown to lead to breast development within the first 12 months, although development may continue through 2-3 years (De Blok, 2020a). Published studies have reported that final breast size varies significantly, anywhere from no growth to a C-cup, although the average individual achieves an A-cup in size.

A prospective case-control study published by Ascha in 2022 investigated the impact of gender affirming mastectomy procedures in a population of transmasculine or nonbinary adolescents and young adults aged between 13 and 24 years (mean 18.6 years). The study involved 36 subjects who underwent gender affirming mastectomy using the surgeon's procedure of choice. An additional 34 subjects seeking medical treatment for gender dysphoria who did not seek chest surgery were used as controls. This group was selected on the basis of age and duration of hormone therapy (±1 year for both) to match the active treatment subjects. The study followed all subjects for 3 months, with 6 surgical group and 5 control group subjects lost to follow-up (15%). Subjects were predominantly white (89%), identified as transgender (84%), and were receiving testosterone therapy (96%). No significant differences between groups were reported with regard to baseline characteristics. Subjects lost to follow-up had significantly higher median scores on the Chest Dysphoria (CDM)

tool and Body Image Scale (BIS), indicating a higher degree of chest-related dysphoria. The authors conducted an inverse probability of treatment weighting (IPTW) model analysis to estimate the association of the surgical procedure with outcomes. The mean significant difference in CDM score from baseline to 3 months for the surgical group was -28.12 vs. -0.52 in the control group subjects. The weighted model results indicated an estimated -25.58 difference between groups, suggesting significant improvement in the surgical group vs. controls. The IPTW model results for Transgender Congruence Scale (TCS) found similar results, indicating a 7.78 point increase in TCS scores between groups in favor of the surgical group. For BIS results, the IPTW model estimated a 7.20 improvement difference between groups, again in favor of the surgery group, indicating improved body satisfaction in the surgical group vs. the controls. This study is one of very few investigating the impact of gender affirming mastectomy in adolescents and young adults. While the results are promising, several issues should be noted. Firstly, it is unclear whether the control group represents a valid comparison group. Secondly, the results of the study may not be generalizable to younger (adolescent) individuals, given that majority of individuals enrolled in the study were 18 years of age and older (and most were between 16 and 21 years of age). Finally, a three month follow-up time may not be sufficient to assess outcomes relevant to the procedure in question or the condition being treated. Additional data from larger, well designed and conducted trials will continue to shed light on the potential benefits and risks of gender affirming mastectomy procedures in adolescents and young adults.

While the WPATH SOC8 recommends only 6 months of GAHT, the international nature of the document should be considered, and that the use of 12 months of GAHT in the U.S. clinical setting is not unreasonable or unattainable. To establish a reconstructive intent, it is important that an individual has undergone a minimum of 12 months of continuous hormonal therapy (when recommended by a mental health professional), and insufficient breast development has occurred.

Furthermore, significant variation in chest anatomy exists amongst cis-gendered individuals. Each individual considering gender affirming chest procedures should be assessed carefully, and significant variation from normal appearance for the experienced gender should be a considered factor in the decision-making process.

Gender Affirming Voice Modification Surgery

Some individuals with gender dysphoria may be dissatisfied with the pitch or other aspects of their voice, which may be considered not in alignment with their experienced gender. In many such cases the use of voice therapy has been shown to provide significant benefits. Additionally, for female-to-male (FtM) individuals, the use of testosterone GAHT alone has been demonstrated to provide the desired results. Conversely, for male-to-female (MtF) individuals, the use of estrogen GAHT has not been shown to provide significant benefits. Use of both voice therapy and GAHT should be considered as first-line approaches for individuals considering gender affirming voice modification surgery. When neither voice therapy nor GAHT are capable of providing the desirable results, gender affirming voice modification surgery may be warranted. It should be noted that the surgical approach poses significant potential risks, including surgical complications, undesired pitch, dysphonia, weak voice, restricted speaking range, hoarseness, and vocal instability.

When gender affirming voice modification is sought for individuals with gender dysphoria, it is considered reconstructive when existing vocal presentation demonstrates significant variation from normal for the experienced gender.

The WPATH SOC8 addresses gender affirming voice modification and provides the following recommendations:

> 14.3- We recommend health care professionals in transgender health working with transgender and gender diverse people who are dissatisfied with their voice or communication consider offering a referral to voice and communication specialists for voice-related support, assessment, and training.
> 14.4- We recommend health care professionals consider working with transgender and gender diverse people who are considering undergoing voice surgery consider offering a referral to a voice and communication specialist who can provide pre- and/or postoperative support.
> 14.5- We recommend health care professionals in transgender health inform transgender and gender diverse people commencing testosterone therapy of the potential and variable effects of this treatment on voice and communication

They additionally state:

> Estrogen treatment in TGD people has not been associated with measurable voice changes (Mészáros et al., 2005), while testosterone treatment in TGD people has been found to result in both desired and undesired changes in gender and function-related aspects of voice production (Azul, 2015; Azul et al., 2017, 2018, 2020; Azul & Neuschaefer-Rube, 2019; Cosyns et al., 2014; Damrose, 2008; Deuster, Di

Vicenzo et al., 2016; Deuster, Matulat et al. 2016; Hancock et al., 2017; Irwig et al., 2017; Nygren et al., 2016; Van Borsel et al., 2000; Yanagi et al., 2015; Ziegler et al., 2018).

WPATH notes that voice surgery to obtain a deeper voice in individuals desiring body masculinization is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Published data evaluating gender affirming voice modification surgery is limited to postoperative satisfaction and vocal outcomes; functional outcomes (for example, quality of life, gender dysphoria symptoms, or sequelae of severe illness, including crisis visits, suicide attempts, etc.) have not been specifically assessed (Kim, 2020).

Gender Affirming Facial Surgery (Return to Clinical Indications)

Gender affirming facial surgery in individuals with gender dysphoria is considered reconstructive when the procedure(s) is(are) intended to address a significant variation from normal appearance for the experienced gender.

The published data regarding gender affirming facial surgery generally support associations between surgery and likelihood of observers identifying an individual by their experienced gender; however, evidence supporting improvements in functional outcomes (for example, quality of life, gender dysphoria symptoms, or sequelae of severe illness, including crisis visits, suicide attempts, etc.) is less clear (Ainsworth, 2010; Cohen, 2018; Fisher, 2020; Morrison, 2020). Available data demonstrates that the long-term use of hormone therapy does quantifiably femininize or masculinize facial features, thus extended use of hormone therapy prior to facial feminization may be warranted in some circumstances (Tebbens, 2019).

In addition to providing general recommendations related to gender affirming surgical procedures, WPATH SOC8 provides specific criteria for the use of gender affirming facial feminization procedures.

Individuals with gender dysphoria who undergo gender affirming procedures may seek additional procedures to further alter their facial appearance when existing facial appearance demonstrates significant variation from normal appearance for the experienced gender. Gender affirming facial surgery may be a single procedure, or a combination or series of procedures. Commonly utilized procedures may include the following:

- Cheek reduction/enhancement
- Chin reduction/enhancement
- Facial bone reconstruction
- Facial implants
- Hair line advancement and/or hair transplant
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Nose implants
- Orbital procedures
- Rhinoplasty
- Thyroid cartilage reduction (chondrolaryngoplasty)

(Return to Clinical Indications)

Other less common procedures listed by WPATH SOC8, such as blepharoplasty, liposuction, brow lift, reduction, or enhancement, may be used to alter facial appearance, when existing facial appearance demonstrates significant variation from normal appearance for the experienced gender.

Gender Affirming Chest Surgery in Individuals Under the Age of 18 (Return to Clinical Indications)

Further consideration may be given for a gender affirming chest procedure in select adolescent individuals between the beginning of puberty through 17 years of age. Extenuating circumstances should be carefully considered, such as the level of maturity of the individual, duration and severity of dysphoric symptoms, coexisting medical and mental health issues, and other factors, which should be carefully documented and considered in consultation with a provider with experience treating adolescents with gender dysphoria.

The WPATH SOC8 provides the following surgical criteria for adolescent individuals:

a. Gender diversity/incongruence is marked and sustained over time;

b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

Furthermore, the WPATH SOC8 provides the following recommendations for adolescents seeking surgical care:

> The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):
> 6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:
> 6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.
> 6.12.b- The experience of gender diversity/incongruence is marked and sustained over time.
> 6.12.c- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
> 6.12.d- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.
> 6.12.e- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
> 6.12.f- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
> 6.12.g- The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

These criteria are provided to help ensure that use of surgical procedures in the treatment of adolescent individuals with gender dysphoria is conducted in a careful, thoughtful manner, taking into consideration multiple factors, including confirmation of the diagnosis of gender incongruence that is "sustained and marked". This is a critical step in the assessment process, given that permanent, irreversible treatment actions are being considered. The WPATH SOC8 addresses this by stating, "Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries." It should be emphasized that WPATH SOC8 states the condition should be present for "*several years"* to establish the incongruity is "sustained".

Confirmation of a diagnosis is important. Gender incongruity may represent the clinical presentation of multiple psychological conditions and careful diagnostic assessment is vital to accurate identification of gender dysphoria symptoms that are likely to respond to gender affirming surgery. Furthermore, as is noted in the DSM-5-TR, "Given the increased openness of gender-diverse expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet specified criteria."

Possession of "adequate emotional and cognitive maturity required to perform informed consent/assent" is critical to help ensure an individual's capacity to fully understand the short- and long-term consequences of any gender affirming surgical procedure. The capacity for adequate maturity may evolve over time with the development of physical and mental changes, beginning with puberty. These attributes may be challenging to assess, and a multidisciplinary approach to evaluation and treatment is strongly recommended. The evaluation process should involve professionals who are

adequately trained and experienced in working with adolescent individuals with potential gender dysphoria, and that they work closely with the individual and their parent(s) or legal guardians.

As discussed above, the use of GAHT may be an important factor in the long-term success of some gender affirming surgical procedures, including some chest procedures. Careful consideration should be taken to allow for the maximal therapeutic effects of GAHT to be established prior to any surgical procedures. The WPATH SOC8 states that a minimum of 12 months of GAHT “to achieve the desired surgical result for gender-affirming procedures, including breast augmentation” may be reasonable.

While WPATH SOC8 provides recommendations in support of surgical procedures other than chest surgery for adolescents, significant controversy surrounds the topic, particularly for gonad and genital procedures. While chest surgery is not fully reversable, other significant risks and complex long-term sequelae accompany gonad and genital surgery, including serious surgical complications and outcomes related to psychological, urinary, sexual, and fertility function. Insufficient consensus has been established to consider gonad and genital surgery for adolescents with gender dysphoria in accordance with generally accepted standards of medical practice.

Referral Letters (Return to Clinical Indications)

An independent assessment of an individual by a qualified mental health professional is considered standard of care before an individual undergoes a gender affirming surgical procedure.

The WPATH SOC8 recommends the following regarding referral letters in support of gender affirming surgery in adults:

> 5.5- We recommend transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment..

They further supply the following criteria for surgical treatment of adults and adolescents, "Health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment should liaise with professionals from different disciplines within the field of trans health for consultation and referral, if required*” and “If written documentation or a letter is required to recommend gender affirming medical and surgical treatment (GAMST), only one letter of assessment from a health care professional who has competencies in the assessment of transgender and gender diverse people is needed”

The WPATH SOC8 includes the following recommendations regarding required opinions prior to gender affirming surgical procedures:

> 5.5- We recommend transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment.
> 6.9- We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.
> 13.7- We recommend surgeons consider gender-affirming surgical interventions for eligible* transgender and gender diverse adolescents when there is evidence a multidisciplinary approach that includes mental health and medical professionals has been involved in the decision-making process.
> 13.8- We recommend surgeons consult a comprehensive, multidisciplinary team of professionals in the field of transgender health when eligible* transgender and gender diverse people request individually customized (previously termed “non-standard”) surgeries as part of a gender-affirming surgical intervention.

From these recommendations, it is clear that a multidisciplinary approach is preferred and multiple experienced and qualified providers should be involved in the decision-making process when a surgical intervention is under consideration. The requirement of more than one opinion is generally not considered overly burdensome in an advanced healthcare setting such as is found in the U.S.

In this guideline, only one letter is required for chest, facial, and voice gender affirming surgical procedures. However, given the potential surgical complications and long-term ramifications on psychological, physical, fertility, and social

function related to gonad and genital gender affirming surgical procedures, it is considered clinically appropriate to require the opinion of two experts involved in the treatment of individuals with gender dysphoria who are considering these interventions.

Additionally, the WPATH SOC8 provides the following recommendations regarding the credentials for mental health professionals who work with adults presenting with gender dysphoria:

> 5.1- We recommend health care professionals assessing transgender and gender diverse adults for physical treatments:
> 5.1.a- 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.
> 5.1.b- For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.
> 5.1.c- Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
> 5.1.d- Are able to assess capacity to consent for treatment.
> 5.1.e- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
> 5.1.f- Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.
> 5.2- We suggest 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.

Procedures to Address Postoperative Complications of Gender Affirming Surgery and Reversal Surgery (Return to Clinical Indications)

Procedures to address postoperative complications of a prior gender affirming surgery (for example, scarring, stenosis, infection, etc.) are not considered separate gender affirming surgery procedures and are not addressed in this document.

Reversal Procedures

Reversal of a prior gender affirming surgery procedure is rare and is considered gender affirming surgery. According to the literature on this issue, the predominant factor in requests for reversals are regret, which has been further associated with age greater than 30 at first surgery, personality disorders, early loss of both parents, social instability, preoperative male heterosexual sexual orientation, degree of social support, secondary transsexualism, early decision to undergo surgery and dissatisfaction with surgical results (Blanchard, 1989; Landén, 1998; Lawrence, 2003; Lindemalm, 1986 and 1987; Olsson, 2006).

Djordjevic (2016) reported on the outcomes of surgical reversal surgery in MtF individuals wishing to transition back to male. While the main focus of this paper is related to surgical outcomes, the authors reported on characteristics of the participating subjects and contributing factors to the reversal decisions. The seven subjects had an absence of "real-life experience" prior to surgery, absence or inappropriate hormonal treatment, recommendations by inexperienced professionals, and insufficient hormonal therapy and medical follow-up. Furthermore, they failed to fulfill the complete diagnostic criteria for gender dysphoria. The authors concluded that the main factor contributing to regret was absence of proper pretreatment assessment. In their reversal protocol, each subject was required to have recommendations from three well-known WPATH psychiatrists prior to reversal procedures.

The available evidence indicates the importance of thorough preoperative physical and psychological evaluation and treatment as being a critical factor in postoperative success. As noted above, these aspects of the treatment process are critical to sufficiently prepare an individual for the social, physical, and mental ramifications of the decision to undergo gender affirming surgery.

The clinical evidence addressing the satisfaction and quality of life following gender affirming surgery is limited, and the reported findings are mixed (Cardoso da Silva, 2016; Castellano, 2015). It is important that proper and thorough pre-operative work-up and preparation be conducted in individuals considering such life-altering procedures. Additionally, long-term post-operative follow-up, including availability of mental health services, may also contribute to satisfaction with surgical results.

Detransitioning

Detransitioning is a term used to refer to individuals who return to the gender assigned at birth following a process of transition to a gender other than the one assigned at birth. Regret may or may not be a component of the detransition process. A small number of published studies involving survey methodology and self-reported data have described detransition cases, the characteristics of the individuals involved, and the factors influencing both. The vast majority of individuals involved in these reports have not undergone gender affirming surgery or undergone reversal procedures.

Turban (2021) reported on a secondary analysis of data derived from the United States Transgender Survey (USTS), a cross-sectional nonprobability sample conducted by the National Center for Transgender People, a non-governmental advocacy organization. The USTS survey includes data from 27,715 transgender respondents aged 18 years or older located in the U.S., its territories, and military. A total of 2242 respondents indicated a history of detransition, which the survey defined as “a process through which a person discontinues some or all aspects of gender affirmation.” Roughly half of the respondents (55.1%) indicated they had received gender affirming hormone therapy, and 16.5% had obtained one or more gender affirming surgical procedures. The authors reported detransition was significantly associated with male sex assigned at birth, non-binary gender, having an unsupportive family, and never having undergone hormone therapy or gender affirming surgery ($p<0.001$ for all). Additionally, 82.5% of respondents cited at least one external factor leading to detransition, including pressure from parents and family, community, or employer. A total of 15.9% cited an internal factor in their decision to detransition, including fluctuations in identity or desire to pursue treatment, and difficulty with the process.

Vandenbussche (2021) reported the results of a 24-multiple choice question online questionnaire involving 237 respondents who positively answered ‘yes’ to the question, “Did you transition medically and/or surgically and then stop?” Respondents were predominantly female (92%). More than half of respondents were from the U.S. (51%), 32% were from Europe, 6% were from Canada, and the remaining were from Australia (5%). Medical and social transition had been conducted by 65% of respondents and 31% had transitioned only socially. Over half (51%) began socially transitioning prior to the age of 18, and 25% began medical transition prior to that age as well. The average duration of transition was 4.71 years. Detransition prior to the age of 18 was reported in 14% of respondents and the average age of detransition was 22.88 years. A total of 45% of respondents indicated that they felt they had not been properly informed of the health implications of the available interventions before undergoing them. Significantly, 70% of respondents reported that their detransition was the result of their realizing their gender dysphoria was related to other issues and 50% reported that transitioning did not help their dysphoria. Other reasons provided for detransitioning were alternatives were found that helped with dysphoria (45%), unhappiness with social transition (44%), and change in political views (43%). In contradiction to the results reported by Turban et al., a lack of social support, financial concerns, and discrimination were at the bottom of reasons listed for detransition (13%. 12%, and 10%, respectively).

In 2021 Littman reported on a survey study of 100 subjects responding to a 115-question online survey who had transitioned and detransitioned medically, surgically, or both. Subjects were recruited via social media platforms. Additional referrals for subjects were sought via professional listservs for WPATH members and sex researchers. Detransition for the purposes of this study was defined as “the act of stopping or reversing a gender transition”. A majority of subjects reported early onset gender dysphoria (56%). The sample population was overwhelmingly white (90%) and female (69%). When asked for the reason behind their initial transition, 71% responded that they believed that transitioning was their only option to feel better. Most respondents (65%) believed that transitioning would eliminate or decrease their gender dysphoria symptoms, and 64% responded that they believed that transitioning would ‘allow them to become their true selves’. Most respondents reported that external factors encouraged them to transition, with online sources the most frequently cited (48%). More than a third (37.4%) felt pressured to transition. Pre-transition care was provided by a wide variety of sources, including gender clinics (44.4%), private practice providers (28%), group practices (26%), mental health clinics (13%). In line with what was previously reported by Turban, a majority of respondents (56.7%) reported feeling that the evaluation they received by their provider prior to their transition was not adequate, with 65% indicating that their provider did not evaluate if their desire to transition was due to trauma or a mental health condition. Only 27% reported that they felt their pre-treatment counseling was sufficiently accurate about the risks and benefits of the desired procedures. Nearly half (46%) indicated that they felt the pre-treatment counseling was overly positive about the benefits of transition and 26 reported that it was not ‘negative enough about the risks’. Chest surgery was the most frequently reported surgical procedure in FtM transitions (33.3%), Genital procedures were reported in 1.4% of FtM transition respondents and 16.1% of MtF transitions. Gender affirming hormone therapy was reported in 96% of subjects. Mean duration of transition was 3.9 years, with FtM transitions shorter than MtF transitions (3.2 vs. 5.4 years, $p=0.018$). The most frequently cited reason for detransitioning was that the respondent “became comfortable with their natal sex” (60%). Other frequently cited reasons included concerns about potential medical complications (49%), transition did not improve their mental health (42%), dissatisfaction with the results of transition (40%), and discovering something specific, such as

trauma or mental health conditions were the cause of their dysphoria (38%). Contrary to Turban, external forces such as discrimination (23%), financial concerns (17%), and online sources (29%) were less prevalent reasons cited for detransitioning. Medical detransition by ceasing hormone therapy was done by 95% of respondents, while reversal procedures were sought by 9%. Retransition after detransition was reported in 3% of subjects. A majority (58%) of respondents stated that their dysphoria was related to trauma or a mental health condition, and 51% stated that transition delayed their receiving proper care for their underlying condition. Underlying internalized homophobia, difficulty accepting oneself as homosexual, was reported as the source of dysphoria in 23% of responses. At the end of the survey period, 61% of respondents had returned to their birth sex, with an additional 10% identifying with their birth sex and 24% identifying as non-binary or non-binary plus a second identification. A third of respondents (30%) had indicated that they wished they had never transitioned, while 11% were glad they had. Thirty-four percent said their transition was a necessary part of their journey and 21% said it had distracted from “what they should have been doing”. Finally, 79% of respondents reported some amount of regret, 49.5% reported strong regret, and 64.6% reported that they would not have chosen to transition had they known what they knew at the time of the survey.

The data surrounding destransitioning is limited, primarily derived from case series that may not represent the general population of individuals presenting with gender dysphoria; however, several important issues should be noted. First, in some individuals, symptoms of gender dysphoria may not be permanent. Second, a careful evaluation should be conducted to help ensure an accurate diagnosis, including assessment of influencing factors such as underlying mental illness, prior trauma, and unidentified homosexuality. Third, external influences such as online resources, family and peer groups may play a significant role in influencing the decision-making process of some individuals seeking care for gender dysphoria. Lastly, early and adequate education regarding the risks and benefits of gender dysphoria treatment should be offered to individuals seeking gender affirming treatment. Additional research is needed to understand the phenomenon of detransitioning, including its prevalence, and internal and external factors that play a role in the process, as well as how diagnostic and counseling support can be utilized to reduce harms, including unnecessary treatment, in individuals presenting with gender dysphoria symptoms.

Other Procedures

Additional surgeries have been proposed to improve the gender appropriate appearance of the individual. Such procedures may be considered cosmetic and are not reconstructive when intended to change a physical appearance that would be considered within normal human anatomic variation or are primarily intended to preserve or improve appearance irrespective of gender-defining features.

Such procedures may include the following, *when one or more of the medical necessary or reconstructive criteria above have not been met*:

A. Bilateral mastectomy
B. Blepharoplasty
C. Breast augmentation
D. Brow lift
E. Face lift
F. Facial bone reconstruction
G. Facial implants
H. Hair removal (for example, electrolysis or laser) and hairplasty
I. Jaw reduction (jaw contouring)
J. Lip reduction/enhancement
K. Lipofilling/collagen injections
L. Lipoplasty
M. Liposuction
N. Nose implants
O. Pectoral implants
P. Rhinoplasty
Q. Thyroid cartilage reduction (chondroplasty)
R. Voice modification surgery

Other procedures are not generally intended to address anatomy directly related to symptoms of gender dysphoria, including the following:

A. Abdominoplasty
B. Body contouring

C. Gluteal implants

Please refer to applicable documents for procedures for individuals with gender dysphoria that *are not related to gender affirming surgery*.

- ANC.00007 Cosmetic and Reconstructive Services: Skin Related
- ANC.00008 Cosmetic and Reconstructive Services of the Head and Neck
- ANC.00009 Cosmetic and Reconstructive Services of the Trunk and Groin
- CG-SURG-03 Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- CG-SURG-12 Penile Prosthesis Implantation
- SURG.00023 Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- TRANS.00037 Uterine Transplantation

Children:

At this time no authoritative organization recommends the use of surgical procedures to treat gender dysphoria in children, defined in the WPATH SOC8 as individuals from birth through the start of puberty. This population has not yet completed the cognitive, emotional, psychological, and social growth needed to have the capacity to fully comprehend issues involved in pre-surgical decision making or to make informed decisions of such a serious nature. Furthermore, it is widely recognized that in this population gender trajectories cannot be predicted and may evolve over time.

Non-Binary, Eunuch and Intersex Individuals

The surgical treatment of non-binary, eunuch and intersex individuals is not specifically addressed in this document; however, when a diagnosis of gender dysphoria been made, the criteria set forth in this document may apply.

Other Guidelines

In late 2017, the Endocrine Society released a clinical practice guideline for the endocrine treatment of gender-dysphoric/gender-incongruent persons (Hembree, 2017). This publication was co-sponsored by the American Association of Clinical Endocrinologists, the American Society of Andrology, the European Society for Pediatric Endocrinology, the European Society of Endocrinology, the Pediatric Endocrine Society, and WPATH. Among other recommendations this document includes the following:

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |±±□□)
2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |±±□□)
2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |±±□□)
2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |±±□□)
2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |±□□□)
5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |±±□□)
5.2. We advise that clinicians approve genital gender affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
5.4. We recommend that clinicians refer hormone treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |±±□□□)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |±±□□).

Note: “MHP” is the Endocrine Society’s abbreviation for “mental health professional”.

Review Considerations:

Reconstructive procedures address features that are distinctly and directly related to gender appearance (or in the case of gender affirming voice modification surgery, vocal presentation), when documentation sufficiently demonstrates significant variation from what is considered normal for the experienced gender. When multiple procedures are requested, each procedure should be considered separately as some procedures may be cosmetic and others may be reconstructive. Procedures primarily intended to preserve or improve appearance (that is: independent of any gender-defining feature or overall gender appearance) are considered cosmetic.

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Index

History

Status	Date	Action
	07/20/2023	Revised Discussion section related to gender affirming chest surgery.

Revised	11/10/2022	Medical Policy & Technology Assessment Committee (MPTAC) review. Added 'Placement of penile or testicular prostheses' to NMN statement. Updated content related to new DSM-5-TR and WPATH SOC8 criteria and recommendations. Revised gender-related language to align with revisions in DSM-5-TR. Updated Discussion and References sections.
Reviewed	05/12/2022	MPTAC review. Updated Discussion and References sections.
Revised	05/13/2021	MPTAC review. Updated title and rest of document to replace "reassignment" with "affirming". Alphabetized procedures in MN statements. Revised gender dysphoria criteria in all MN statements. Added "or intolerance" to hormone therapy in related MN criteria. Clarified hair removal MN statement. Moved bilateral mastectomy from MN to Reconstructive section. Added breast augmentation and breast reduction procedures to Reconstructive section. Moved gender affirming facial feminization procedures and voice modification surgery from Cosmetic and NMN to Reconstructive section. Removed voice therapy from scope of document. Clarified the NMN statement and Cosmetic and NMN statement. Revised Further Considerations statement to include breast augmentation and breast reduction procedures. Updated Discussion and References sections. Updated Coding section with additional codes for facial and chest surgery.
Revised	02/11/2021	MPTAC review. Clarified note regarding number of letters required for mastectomy procedures. The phrase "cosmetic" was clarified to read "cosmetic and not medically necessary". Updated Description, Coding and References sections.
	12/16/2020	Updated Coding section with 01/01/2021 CPT changes, revised descriptors for codes 19318, 19325; removed deleted ICD-10-PCS codes.
Revised	08/13/2020	MPTAC review. Added penile prostheses to MN statement addressing phalloplasty procedures. Updated Description and References sections. Reformatted Coding section and added codes 54400, 54401, 54405, 55899, C1813, C2622, L8699.
Revised	05/14/2020	MPTAC review. Added text to MN statement for mastectomy referring reader to see Further Considerations section for individuals under 18 years of age. Added new Further Considerations section addressing mastectomy procedures for individuals under 18 years of age. Updated Description, Discussion, References and Index sections.
	04/01/2020	Updated Coding section; added CPT 19318 and removed deleted code 19304.
Revised	11/07/2019	MPTAC review. Updated title and document contents to replace "sex reassignment" with "gender reassignment" and "his or her" with "their". Made minor language revisions to Clinical Indications section. Clarified MN statement regarding hair removal procedures. Added text to the Background section regarding WPATH recommendations for the content of referral letters. Updated Discussion and References sections. Updated Coding section with 01/01/2020 CPT changes; noted 19304 is deleted effective 12/31/2019.
Revised	01/24/2019	MPTAC review. Revised MN criteria for bilateral mastectomy to require one referral letter. Added new notes addressing treatment of postoperative complications and reversal procedures. Updated Discussion, Coding, and References sections.
Revised	11/08/2018	MPTAC review. Added criteria for referral letters to mastectomy MN statement.
Revised	03/22/2018	MPTAC review.
Revised	02/23/2018	Behavioral Health Subcommittee review. Clarification of mastectomy criteria to remove specification that a female must be transitioning to be a male. Clarification of several Cosmetic indications.
	01/01/2018	The document header wording updated from "Current Effective Date" to "Publish Date." Updated Coding section; removed CPT 55970, 55980 (not applicable).
Revised	08/03/2017	MPTAC review.
Revised	07/21/2017	Behavioral Health Subcommittee review. Added note regarding timing of "top" and "bottom" surgical procedures. Added new statement regarding nipple reconstructions following mastectomy. Updated Coding and References sections.
Revised	02/02/2017	MPTAC review.
Revised	01/20/2017	Behavioral Health Subcommittee review. Updated criteria regarding confirmation of female gender prior to bilateral mastectomy in female-to-male transitions. Updated Reference sections.
Revised	08/04/2016	MPTAC review.

Revised	07/29/2016	Behavioral Health Subcommittee review. Updated formatting in the Clinical Indications section. Added bilateral mastectomy to MN section with criteria. Updated Reference sections. Updated Coding section to include 10/01/2016 ICD-10-CM changes.
Revised	05/05/2016	MPTAC review. Revised title from “Gender Reassignment Surgery” to “Sex Reassignment Surgery”. Updated Coding, Rationale and Discussion section.
Revised	02/04/2016	MPTAC review.
Revised	01/29/2016	Behavioral Health Subcommittee review. Added new medically necessary statement addressing the use of hair removal procedures to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure. Added additional procedures to Cosmetic statement. Updated Coding and Rationale sections. Removed ICD-9 codes from Coding section.
Revised	08/06/2015	MPTAC review.
Revised	07/31/2015	Behavioral Health Subcommittee review. Revised text regarding educational and professional qualifications required for individuals submitting referral letters to include master’s-level practitioners. Added text to referral letter criteria, requiring that letters need to be no more than 12 months old at time of request. Revised criteria regarding hormone therapy requirements. Replaced the word ‘surgeries’ with ‘procedures’ in Cosmetic statement. Added note to Cosmetic section.
Reviewed	08/14/2014	MPTAC review.
Reviewed	08/08/2014	Behavioral Health Subcommittee review.
Revised	08/08/2013	MPTAC review.
Revised	07/26/2013	Behavioral Health Subcommittee review. Revised document text to align with new DSM-5 terminology and diagnostic criteria. Updated Discussion and Reference sections.
Revised	08/09/2012	MPTAC review.
Revised	08/03/2012	Behavioral Health Subcommittee review. Created separate criteria sets for gonad and reproductive organ procedures and for external genital procedures in alignment with the WPATH SOC7. Deleted the criteria requiring 12 months of continuous living in desired gender role from the reproductive organ procedures criteria set. Deleted criteria requiring “Demonstrable knowledge of the required length of hospitalizations, likely complications, and post-surgical rehabilitation requirements of various surgical approaches”. Deleted “not due to chromosomal abnormality” from medically necessary criteria. Updated Coding, Discussion and Reference sections.
Revised	02/16/2012	MPTAC review.
Revised	02/10/2012	Behavioral Health Subcommittee review. Significantly revised the medically necessary to align with new 2012 WPATH Standards of Care document. Updated Rationale and Reference sections.
Reviewed	05/19/2011	MPTAC review.
Reviewed	05/13/2010	MPTAC review. Updated Reference section.
Reviewed	11/19/2009	MPTAC review. Updated Coding section with 01/01/2010 CPT changes.
Reviewed	11/20/2008	MPTAC review. Updated Coding section.
Reviewed	11/29/2007	MPTAC review. Updated Coding section with 01/01/2008 CPT changes.
New	12/07/2006	MPTAC initial guideline development.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

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been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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