Trans Health Project

Working for Transgender Equal Rights

Health Insurance Medical Policies

Breast Reconstruction

These are a list of clinical criteria that have explicit coverage for breast augmentation for transgender women.

Policy Issued By: Aetna

Policy Title: Gender Affirming Surgery

Breast Reconstruction:

Requirements for breast augmentation (implants/lipofilling):

Note: More than one breast augmentation is considered not medically necessary. This does not include the medically necessary replacement of breast implants (see CPB 0142 - Breast Implant Removal).

Policy Issued By: Amida Care

Policy Title: Clinical Guidelines and Coverage Criteria for the Treatment of Gender Dysphoria

Breast Reconstruction:

Amida Care performs administrative prior authorizations only for the following procedures included in 18 NYCRR 505.2(l), paragraph 4: ... breast augmentation.

The member has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the patient is otherwise unable to take hormones

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Policy Issued By: Anthem

Policy Title: Gender Affirming Surgery

Breast Reconstruction:

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

1. The individual is at least 18 years of age (see *Further Considerations* section below for individuals under 18 years of age); **and**
2. The individual has capacity to make fully informed decisions and consent for treatment; **and**
3. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**

4. 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**
5. *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**
6. 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**
7. 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.

Policy Issued By: Anthem Blue Cross (California)

Policy Title: Gender Affirming Surgery

Breast Reconstruction:

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

1. The individual is at least 18 years of age (see *Further Considerations* section below for individuals under 18 years of age); **and**
2. The individual has capacity to make fully informed decisions and consent for treatment; **and**
3. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**
4. 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**
5. *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**
6. 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**
7. 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.

Policy Issued By: Aspirus Arise

Policy Title: Gender Dysphoria Treatment

Breast Reconstruction:

Requirements for ... breast augmentation (augmentation mammoplasty and breast implants) in male-to-female (MtF) individuals: ... It is recommended (although not required) that male-to-female individuals undergo feminizing hormone therapy for a minimum of 12 months prior to breast augmentation surgery in order to maximize breast growth and obtain better surgical results.

Policy Issued By: Blue Cross and Blue Shield of Alabama

Policy Title: Transgender Services Benefits

Breast Reconstruction:

A member must meet **ALL** the following criteria established under the World Professional Association for Transgender Health (WPATH) (7th version) in order to be **eligible:**

1. Diagnosis of **Gender Identity Disorder** (ICD-10 F64.0, F64.1 or F64.9); **and**
2. **Age of majority** (18 years of age or older); **and**
3. **Have knowledge of the benefits and risks of surgery** as demonstrated by and documented in an evaluationfrom a qualified mental health professional; **and**
4. Unless medically contraindicated, **completion of twelve (12) months of continuous hormone therapy** (EXCEPT for Mastectomy); **and**
5. **Twelve continuous months of living in a congruent gender role with his/her gender identity** (real life experience) **prior to the gender reassignment services** noted in the medical documentation (start/end dates included); **and**
6. If the member has **significant medical or mental health issues present,** they must be **reasonably well controlled** and noted in the medical documentation. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., 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 prior to surgery and the effort(s) noted in the medical documentation; **and**
7. **Two (2) referrals from qualified mental health professionals** who have independently assessed the individual. 1 referral should be from a person who has only had an evaluative role with the individual. Both referring providers must submit letters of their evaluation. (At least 1 of the evaluating professionals must have a doctoral degree [PhD, MD, Ed.B, D. Sc, D.S.W. or Psy.D] and be capable of adequately evaluating co-morbid psychiatric conditions.)

BREAST DEVELOPMENT - female hormones for at least 12 months to achieve adequate breast development without surgery. Any further intervention by surgical means would be reviewed for medical necessity in accordance with medical policy #106 Reconstructive versus Cosmetic Surgery.

Policy Issued By: Blue Cross Blue Shield of New Mexico

Policy Title: Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Breast Reconstruction:

The individual being considered for surgery and related services must meet **ALL** the following criteria. The individual **must have**:

- Reached the age of majority; **AND**
- The capacity to make a fully informed decision and to consent for treatment; **AND**

- Been diagnosed with persistent, well-documented gender dysphoria; **AND**
- The required referrals prior to any surgery or related service(s):

o Prior to breast/chest surgery, e.g., mastectomy, chest reconstruction, or breast augmentation, one required referral from the individual's qualified mental health professionals (see **NOTE 1** below) competent in the assessment and treatment of gender dysphoria

NOTE 1: Psychotherapy and Mental Health Services:

Psychotherapy is not required for gender reassignment services except when a mental health professional recommends psychotherapy based on initial assessment prior to gender reassignment surgery. The recommendation for psychotherapy must specify the goals of treatment along with estimates of the frequency and duration of therapy throughout the individual's experience living in one's affirmed gender. Review the criteria above under "Criteria for Coverage of Gender Reassignment Surgery and Related Services" for required surgical referral letters from qualified mental health professionals.

Male-to-Female (MtF) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

- Breast modification, including but not limited to breast enlargement, breast augmentation, mastopexy, implant insertion, and silicone injections, and nipple or areola reconstruction

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Policy Issued By: Boston Medical Center HealthNet Plan / Well Sense

Policy Title: Gender Affirmation Surgeries

Breast Reconstruction:

(1) Breast Augmentation (Feminizing Chest Reconstruction): This policy includes medical necessity criteria for the initial breast augmentation procedure as a component of gender affirmation surgery. Feminizing breast reconstruction for members with persistent, well-documented gender dysphoria includes augmentation mammoplasty with implantation of breast prostheses and/or the medically necessary surgical removal of breast implants with replacement of breast implants after implant explantation [sic].

Plan Medical Director review and approval are required when mastopexy and/or breast reconstruction are requested for the treatment of gender dysphoria (as a treatment alternative to augmentation mammoplasty) for feminizing breast reconstruction, as stated in the Limitations section of this policy. Review criteria in the Medical Policy Statement section of the Breast Reconstruction medical policy, policy number OCA 3.43, rather than the criteria included in this policy for Plan prior authorization guidelines for the surgical removal of breast implants and the replacement of breast implants after implant explantation [sic] (when the breast implants were initially inserted for breast reconstruction as a component of gender affirmation surgery).

Augmentation mammoplasty with implantation of breast prostheses (feminizing chest reconstruction) is considered medically necessary for members with persistent, well documented gender dysphoria when ALL of the following criteria are met for the initial breast augmentation for gender affirmation surgery and documented in the member's medical record, as specified below in items (a) through (d):

(a) The treating surgeon has determined that the member has the capacity to make a fully-informed decision and has the capacity to consent for treatment (including parental or guardian consent, as applicable, if the member is younger than age 18 on the date of service

or informed consent is obtained from an emancipated minor according to state requirements); AND

(b) If significant medical and/or mental health concerns are present, the treating surgeon has determined that the conditions are being optimally managed and are reasonably well controlled; AND

(c) The member has had 12 continuous months of physician-supervised hormone therapy (unless hormone therapy is medically contraindicated for the member), and the hormone therapy has not resulted in sufficient breast development as self-reported by the member to the treating provider; OR

(d) The treating surgeon has reviewed the written initial assessment by a qualified licensed mental health professional; the surgeon has confirmed that this assessment documents that the member has met DSM-5 criteria for persistent, well-documented gender dysphoria; and the treating surgeon is in agreement with the member's diagnosis; AND ^ Note: The written assessment may be from the qualified licensed mental health professional performing the initial assessment/referral referenced in item A of this section (Referral/Initial Assessment by Qualified Licensed Mental Health Professional criteria).

Policy Issued By: CareSource

Policy Title: Gender Dysphoria (Georgia Medicaid)

Breast Reconstruction:

SERVICES REQUIRING MEDICAL NECESSITY REVIEW

1. All members requesting ANY of the sexual reassignment surgeries (see list below).
    1. MtF
        1. 01. Breast reconstruction

Policy Issued By: CareSource

Policy Title: Gender Dysphoria (Indiana Medicaid)

Breast Reconstruction:

SERVICES REQUIRING MEDICAL NECESSITY REVIEW

1. All members requesting ANY of the sexual reassignment surgeries (see list below).
    1. MtF
        1. 01. Breast reconstruction

Policy Issued By: CareSource

Policy Title: Gender Dysphoria (Ohio Marketplace)

Breast Reconstruction:

SERVICES REQUIRING MEDICAL NECESSITY REVIEW

1. All members requesting ANY of the sexual reassignment surgeries (see list below).
    1. MtF
        1. 01. Breast reconstruction

Policy Issued By: CareSource

Policy Title: Gender Dysphoria (Ohio Medicaid)

Breast Reconstruction:

The following are requirements that apply for consideration of sexual reassignment surgery: (List is not meant to represent all requirements)

1. Breast/chest surgery

a. Unless contraindicated or is unable to take, individual has participated in 12 consecutive months of cross-sex hormone therapy for the desired gender.

b. Hormone trial must be with a medication prescribed to the member

d. One letter of recommendation from a QMHP to the surgeon is required

1. QMHP has evaluated the member within the past twelve months of the time of referral
2. If member has been in behavioral health treatment, it is preferred that the recommendation is made by the behavioral health treatment provider (if the provider is a QMHP)
3. If there is not a treating QMHP, a letter of recommendation may be made by a consulting QMHP
4. If the QMHP is a member of a treatment team with the surgeon, documentation in the integrated clinical record is an option in lieu of a letter
5. Content of the QMHP referral letter must address at minimum:

(1) Duration of evaluator's relationship with the member

(2) Member has well-documented diagnosis of gender dysphoria

(3) A member specific treatment plan

(4) Member has capacity to give informed consent for surgery

(5) Member is age 18 years or older

(6) Member has had a twelve-month or longer real-life experience congruent with their gender identity

(7) The gender dysphoria diagnosis has been consistently persistent for a duration of 6 months or longer at the time of the authorization request.

(8) If co-existing mental illness substance related disorder are present, it is relatively well controlled, there has been no active intravenous drug use for the past 3 months and no suicide attempts or behaviors in the past 6 months.

(9) QMHP communicates willingness to be available to treat the member during transition or make appropriate referral if member needs assistance with behavioral health treatment

Sexual reassignment surgery

1. All members requesting ANY of the sexual reassignment surgeries (see list below).

a. MtF

01. Breast reconstruction

Policy Issued By: Cigna

Policy Title: Gender Dysphoria Treatment

Breast Reconstruction:

Initial breast reconstruction including augmentation with implants is covered.

Policy Issued By: Fallon Health

Policy Title: Gender Affirmation Services

Breast Reconstruction:

This specific criteria applies to mastectomies for Female to Male, breast augmentations for Male to Female, and all genital surgeries. Fallon Health may authorize the coverage of transgender surgery procedures when all of the following criteria are met, the request must be supported by the treating provider(s) medical records:

1. The member is 18 years of age or older;
2. Has a definitive diagnosis of persistent Gender Dysphoria that has been made and documented by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field. Fallon Health reserves the right to request the credentials of this mental health professional.
3. The member has received continuous hormone therapy for 12 months or more under the supervision of a physician with documentation of the member's compliance and the type, frequency, and route of administration;
4. The member has lived as their chosen or reassigned gender full-time for 12 months or more; (3 and 4 may occur concurrently)
5. For gender reassignment surgery, the member's medical and mental health providers document that there are no contraindications to the planned surgery and agree with the plan.

Policy Issued By: Gateway Health

Policy Title: Gender Transition Services

Breast Reconstruction:

Gender transition surgery involving the masculinization of breast/chest surgery is considered medically necessary when all of the following criteria are met:

Persistent, well documented diagnosis of gender dysphoria, including the following:

1. The desire to live and be accepted as a person whose gender is different than assigned at birth, typically accompanied by the desire to make the physical body as congruent as possible with the identified gender through surgery and hormone treatment; AND
2. The desire for alternate gender identity has been present for at least 6 months; AND
3. The gender dysphoria causes clinical distress or social impairment in social, occupation, or other important areas of functioning; AND Minimum of 18 years of age, or on a case-by-case basis, the minimum age of 18 years may be reconsidered for mastectomy surgeries if sufficient documentation is provided, all other criteria have been met, and the presence of breasts precludes the patient from successfully adopting a male or androgynous gender role; AND When significant medical or mental health issues are present, there must be attempts to achieve reasonable control. There should be an independent single referral from a qualified mental health professional.

The following gender confirmation surgeries are eligible services when all of the above criteria are met:

A. Transwomen (male to female): ... Augmentation mammoplasty

Policy Issued By: Harvard Pilgrim Health Care (Stride HMO Medicare Advantage)

Policy Title: Transgender Health Services

Breast Reconstruction:

Harvard Pilgrim Health Care (HPHC) considers transgender surgical services as medically necessary when documentation and letters confirm ALL of the following for transgender breast/chest surgery:

1. Member age 18 years or older has been diagnosed, by an appropriately trained Mental Health Professional (MHP), with gender dysphoria/gender incongruence; AND
2. Transgender surgery has been recommended by ONE treating clinicians
3. Capacity to make fully informed decisions and to consent for treatment
4. If significant medical or mental health concerns are present, they must be reasonably well controlled

Transfeminine surgeries covered include:

- Augmentation mammoplasty

Policy Issued By: Horizon Blue Cross Blue Shield of New Jersey

Policy Title: Gender Reassignment/Gender Affirming Surgery

Breast Reconstruction:

1. Criteria for **mastectomy** and **creation of a male chest** in female-to-male members:
   1. Single letter of referral from a qualified mental health professional *(see Policy Guidelines II, III)*, and
   2. Persistent, well-documented gender dysphoria *(see Policy Guidelines I*); and
   3. Capacity to make a fully informed decision and to give consent for treatment; and
   4. Age of majority (18 years of age or older) - For members younger than 18 years of age, please see *NOTE* below; and
   5. If significant medical or mental health concerns are present, they must be reasonably well controlled.
      *(**NOTE:** Hormone therapy is not a prerequisite.*
      According to the WPATH Standards of Care 7th Edition, "Chest surgery in female-to-male patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.")
2. Criteria for **breast augmentation** (implants/lipofilling) in male-to-female members:
   1. Single letter of referral from a qualified mental health professional *(see Policy Guidelines II, III)*, and
   2. Persistent, well-documented gender dysphoria (*see Policy Guidelines I)*; and
   3. Capacity to make a fully informed decision and to give consent for treatment; and
   4. Age of majority (18 years of age or older); and
   5. If significant medical or mental health concerns are present, they must be reasonably well controlled.
      *(**NOTE:** Although not an explicit criterion, WPATH Standards of Care (Revision 7 p. 65) recommended that male-to-female members undergo feminizing hormone therapy*

(minimum of 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical/aesthetic results.)

Policy Issued By: Husky Health Connecticut (Medicaid)

Policy Title: Gender Reassignment Services

Breast Reconstruction:

Mastectomy and creation of a male chest may be considered medically necessary as part of female to male gender affirmation when all of the following criteria are met:

1. The individual has capacity to make fully informed decisions and consent for treatment; and
2. The individual has been diagnosed with gender dysphoria, and exhibits all of the following:
    1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
    2. The transsexual identity has been present persistently for at least two years; and
    3. The disorder is not a symptom of another mental disorder; and
    4. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
3. If the individual has significant, outstanding medical or mental health conditions present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic, 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
4. One referral from a qualified mental health professional who has assessed the individual.

Policy Issued By: Independence Blue Cross

Policy Title: Treatment of Gender Dysphoria

Breast Reconstruction:

Breast augmentation is considered medically necessary and, therefore, covered, when all of the following criteria are met:

- The individual has persistent, well-documented gender dysphoria in accordance with the criteria established in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, [DSM-5]*.
- Breast augmentation is recommended by a qualified professional provider who has consistently monitored the individual up to the time of surgery.
    - One referral letter and/or chart documentation must be written from the mental health professional provider who consistently monitored the individual throughout their psychotherapy or any other evaluation to the professional provider who will be responsible for the individual's treatment.
- The individual is at least 18 years of age.
- The individual, unless medically contraindicated, has used feminizing hormones continuously and responsibly (which may include screenings and follow-ups with the professional provider) for a 12-month period.

- The individual, if required by a mental health professional provider, has regularly participated in psychotherapy throughout the real-life experience at a frequency determined jointly by the individual and the mental health professional provider.
- If the individual has significant medical or mental health concerns, they are reasonably well controlled.

Policy Issued By: Independence Blue Cross

Policy Title: Treatment of Gender Dysphoria (Medicare Advantage)

Breast Reconstruction:

BILATERAL MASTECTOMY
Bilateral mastectomy is considered medically necessary and, therefore, covered, when all of the following criteria are met:

- The individual has persistent, well-documented gender dysphoria in accordance with the criteria established in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, [DSM-5]* .
- Bilateral mastectomy is recommended by a qualified professional provider who has consistently monitored the individual up to the time of surgery.
  - One referral letter and/or chart documentation must be written from the mental health professional provider who consistently monitored the individual throughout their psychotherapy or any other evaluation to the professional provider who will be responsible for the individual's treatment.
- The individual is at least 18 years of age.
- The individual, if required by the mental health professional provider, has regularly participated in psychotherapy throughout a real-life experience (living in a gender role that is congruent with an individual's gender identity) at a frequency determined jointly by the individual and the mental health professional provider.
- If the individual has significant medical or mental health concerns, they are reasonably well controlled.

BREAST AUGMENTATION
Breast augmentation is considered medically necessary and, therefore, covered, when all of the following criteria are met:

- The individual has persistent, well-documented gender dysphoria in accordance with the criteria established in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, [DSM-5].*
- Breast augmentation is recommended by a qualified professional provider who has consistently monitored the individual up to the time of surgery.
  - One referral letter and/or chart documentation must be written from the mental health professional provider who consistently monitored the individual throughout their psychotherapy or any other evaluation to the professional provider who will be responsible for the individual's treatment.
- The individual is at least 18 years of age.
- The individual, unless medically contraindicated, has used feminizing hormones continuously and responsibly (which may include screenings and follow-ups with the professional provider) for a 12-month period.
- The individual, if required by a mental health professional provider, has regularly participated in psychotherapy throughout a real-life experience (living in a gender role that is congruent with an individual's gender identity) at a frequency determined jointly by the individual and the mental health professional provider.

- If the individual has significant medical or mental health concerns, they are reasonably well controlled.

Policy Issued By: Inland Empire Health Plan (IEHP) (Medi-Cal)

Policy Title: Gender Dysphoria

Breast Reconstruction:

Chest and Genital Gender-Affirming Surgical Consultation:

1. The individual must have a diagnosis of persistent gender dysphoria.
2. The individual must be able to provide informed consent. Feminizing/masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment.
3. A Medical Evaluation Form is to be completed (see Attachment B). Alternatively, the Provider may submit the same content in the clinical documentation.
4. The Provider or Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (see Attachment C). Alternatively, a letter from the Provider addressing the same content as Attachment C is acceptable.

a. One form/letter (for chest surgeries) from an individual's treating Primary Care Provider or mental health professional endorsing the request in writing is required for the following chest surgeries:

i. (M to F) Augmentation mammoplasty;

Policy Issued By: Louisiana Healthcare Connections (Centene Corporation - Medicaid)

Policy Title: Gender-Affirming Procedures

Breast Reconstruction:

Services for gender affirmation most often include ... chest reconstruction or augmentation as appropriate.

Policy Issued By: Mass General Brigham Health Plan

Policy Title: Gender Affirming Procedures

Breast Reconstruction:

Chest/Breast Surgeries

Mass General Brigham Health Plan covers bilateral mastectomy, breast augmentation, breast reduction (MassHealth only), chest reconstruction/contouring and nipple/areolar complex reconstruction when the requirements as noted above are met and documentation has been submitted from one qualified behavioral health provider. For transmasculine members, there is no requirement for hormone therapy. Although not an explicit criterion, it is recommended that transfeminine members undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Policy Issued By: Minnesota Health Care Programs

Policy Title: Gender-Confirming Surgery

Breast Reconstruction:

In addition to these specific covered procedures, the following procedures may also be covered when medically necessary:

- Breast augmentation surgery for male-to-female GCS when the patient exhibits no response after adhering to hormone therapy for at least 24 months (unless contraindicated) and gender dysphoric symptoms remain after hormone treatment

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Policy Issued By: Neighborhood Health Plan of Rhode Island

Policy Title: Gender Dysphoria Treatment

Breast Reconstruction:

Gender reassignment surgeries/procedures listed in Tables I and II require prior authorization and are covered for transmen or transwomen when documentation submitted confirms that all of the following criteria are met:

- Member is 18 years of age or older
- Member has the capacity to make fully informed decisions including consent to treatment.
- Gender Dysphoria has been diagnosed by qualified health provider(s) and is a persistent diagnosis o Member has successfully lived full-time in the desired gender role without retuning to the original gender for a minimum of 12 months.
- Face to face comprehensive evaluation and treatment plan by the provider administering hormonal therapy and by the *surgeon performing requested surgery.
- A behavioral health evaluation, supporting candidacy for gender-confirming surgery, performed within 6 months of the request for authorization for surgery.
- Attestation that the member is adhering to medical and behavioral health treatment as recommended and is medically and behaviorally stable.
- Attestation that the member has access to primary care provided by a clinician who is has an understanding of gender dysphoria and who can perform and coordinate follow up care including appropriate screenings and monitoring.
- The treatment plan must conform to WPATH standards and/or to other evidence-based, agreed- upon, external guidelines.
- * Surgeons must have demonstrated training, experience, and proficiency in performing the requested surgical procedure.
- Breast Augmentation mammaplasty requires documentation by the physician prescribing hormones and the surgeon that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role.

Policy Issued By: New York

Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

BREAST/CHEST SURGERY

In addition to the criteria 1-3 and 5 above, the following criterion must also be met for individuals undergoing breast/chest surgeries:

8. One referral from a qualified mental health professional who has independently assessed the individual is documented. Gender affirmation surgery is considered not medically

necessary when one or more of the criteria above have not been met. Medically necessary male to female sex affirmation surgical procedures include the following:

• Orchiectomy • Penectomy • Vaginoplasty • Clitoroplasty • Labiaplasty Medically necessary female to male sex affirmation surgical procedures include the following: • Hysterectomy • Salpingo-oophorectomy • Vaginectomy/colpectomy • Initial mastectomy/breast reduction • Nipple reconstruction, including tattooing, following a mastectomy • Urethroplasty • Metoidioplasty • Phalloplasty • Scrotoplasty

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Policy Issued By: Oregon Health Authority (Oregon Health Plan)

Policy Title: Prioritized List of Health Services - Gender Dysphoria/Transsexualism

Breast Reconstruction:

Mammoplasty (CPT 19316, 19324-19325, 19340, 19342, 19350) is only included on this line when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale OR there is any contraindication to, intolerance of or patient refusal of hormonal therapy.

Sex reassignment surgery is included for patients who are sufficiently physically fit and meet eligibility criteria. To qualify for surgery, the patient must:

A) have persistent, well documented gender dysphoria

B) for genital surgeries, have completed twelve months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not clinically indicated for the individual

C) have completed twelve months of living in a gender role that is congruent with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient

D) have the capacity to make a fully informed decision and to give consent for treatment

E) have any significant medical or mental health concerns reasonably well controlled

F) for breast/chest surgeries, have one referral from a mental health professional provided in accordance with version 7 of the WPATH Standards of Care.

Policy Issued By: UniCare (Anthem)

Policy Title: Gender Affirming Surgery

Breast Reconstruction:

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

1. The individual is at least 18 years of age (see *Further Considerations* section below for individuals under 18 years of age); **and**
2. The individual has capacity to make fully informed decisions and consent for treatment; **and**
3. The individual has been diagnosed with gender dysphoria (see Discussion section for diagnostic criteria); **and**
4. 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**

5. *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**
6. 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**
7. 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.

Policy Issued By: Visiant (Medicare Advantage Medical Policy for Premera Blue Cross)

Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

- One comprehensive evaluation and recommendation within the last six months from a licensed mental health professional (see Guidelines below), AND
- Diagnosis of gender dysphoria (formerly gender identity disorder) confirmed by the evaluating mental health professional, AND
- 18 years of age or older, AND
- No medical contraindications to surgery

In addition, for augmentation mammaplasty for male to female patients, one of the following must be met:

- failure of breast growth stimulation by estrogen (progression only to a young adolescent stage of development), OR
- emergence of serious or intolerable adverse effects during estrogen administration, OR
- medical contraindication to use of estrogen, OR
- risk-benefit analysis determined that surgery is preferable to estrogen therapy

Note: The criteria above apply for initial male to female augmentation mammaplasty, Additional breast augmentation after an initial augmentation mammaplasty is considered to be a feminization or cosmetic procedure, and therefore, member contract stipulations for feminization or cosmetic procedures (either contract exclusion or coverage criteria, whichever is applicable for the member's health plan) apply.

Correction or repair of complications:

Surgery to correct or repair complications of gender altering genital or breast/chest surgery may be considered medically necessary for complications that cause significant discomfort or significant functional impairment. Surgery to revise, or to reverse and redo, specific gender altering genital or breast/chest procedures, may be considered medically necessary when correction or repair of complications requires revision or undoing of the original genital or breast/chest procedure. (Example: Baker IV contracture after breast augmentation necessitates removal of the implants, and replacement with smaller implants.)

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