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:** Ambetter from Buckeye Health Plan (Centene Corporation)

**Policy Title:** Gender-Affirming Procedures

**Breast Reconstruction:**

Procedures for transwomen (male to female) include ... Mammoplasty

**Policy Issued By:** Amerigroup (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: AmeriHealth

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: AmeriHealth Caritas of Louisiana

Policy Title: Gender Dysphoria

Breast Reconstruction:

Breast/Chest Surgery. Breast augmentation and mastectomy for female to male (transmen) and creation of male chest for male to female (transwomen) members are considered medically necessary when the following criteria are met:

1. Persistent gender dysphoria is well documented.

2. Member has the capacity to make informed decisions and consent to treatment.

3. Member is of majority (adults only).
4. Any significant medical or mental health concerns are controlled.
5. Member has had at least 12 months of feminizing hormone therapy (recommended for breast augmentation).
6. One letter of referral is submitted.

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.

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.

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**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.

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**Policy Issued By:** Asuris

**Policy Title:** Transgender Services

**Breast Reconstruction:**

All of the following general criteria must be met for surgical gender affirming interventions for gender dysphoria to be considered for coverage:

A. Age at least 18 years (Note: age requirement will not be applied to mastectomy with documented provider determination of medical necessity of earlier intervention); and

B. Clinical records document that the patient has the capacity to make fully informed decisions and consent for intervention, and that any other mental health condition, if present, is adequately controlled; and
C. At least 2 licensed mental health professionals have diagnosed gender dysphoria, and recommend surgical intervention (Note: only 1 mental health professional referral is required for mastectomy); and

D. Documentation of continuous hormonal therapy for at least 12 months, unless there is a documented contraindication to hormonal therapy (Notes: hormonal therapy is not required prior to mastectomy; hormonal therapy for at least 6 months is required for endometrial ablation); and

E. Twelve months of living in a role that is congruent with the patient’s identity.

Any of the following procedures may be considered medically necessary when clinical information is submitted expressly documenting that the intervention would improve otherwise documented significant gender dysphoria, and all of Criteria II.A.-E. above are met:

1. Breast augmentation ...
2. Labiaplasty
3. Vaginoplasty
4. Clitoral hooding
5. Mastopexy

Policy Issued By: BlueChoice Healthplan of South Carolina

Policy Title: Gender Affirming Surgery

Breast Reconstruction:

Reconstructive

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.

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

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 evaluation from 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 and Blue Shield of Florida

Policy Title: Gender Affirmation Surgery

Breast Reconstruction:

Breast augmentation (implants/lipofilling) for male to female members meets the definition of medical necessity when **ALL** of the following are met:

A. **Member is 18 years or older**
B. **Member has the capacity to make a fully informed decision and to consent for treatment**
C. **Documentation shows persistent and well documented gender dysphoria**
D. **No medical contraindications to surgery**
E. **Any mental health concerns are well controlled**
F. **Documentation of 12 continuous months of hormone therapy** (unless the member has a medical contraindication or is otherwise unable to take hormones); **AND** G. One referral letter from a licensed mental health professional.
Policy Issued By: Blue Cross Blue Shield of Illinois

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):

- Prior to feminizing or masculinizing hormonal therapy, one required referral from the individual's qualified mental health professional (see NOTE 2) competent in the assessment and treatment of gender dysphoria; and/or
- Prior to breast/chest surgery, e.g., mastectomy, chest reconstruction, or breast augmentation, one required referral from the individual's qualified mental health professional (see NOTE 2) competent in the assessment and treatment of gender dysphoria; and/or
- Prior to any genital surgery, e.g., hysterectomy, salpingo-oophorectomy, orchietomy, and/or other genital reconstructive procedures, two separate required independent referrals (or one signed by both referring providers) from the individual's qualified mental health professionals (see NOTE 2) competent in the assessment, treatment of gender dysphoria, and addressing the identical/same surgery to be performed.

NOTE 2: 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.

Policy Issued By: Blue Cross Blue Shield of Massachusetts

Policy Title: Gender Affirming Services (Transgender Services)

Breast Reconstruction:

Breast augmentation for transfeminine members may be considered MEDICALLY NECESSARY when ALL of the following candidate criteria are met:

- Age ≥ 18,
- The candidate has been diagnosed with gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder), including meeting ALL of the following indications:
  - The desire to live and be accepted as a member of another gender other than one's assigned sex, typically accompanied by the desire to make the physical body as congruent as possible with the identified gender through surgery and hormone treatment.
  - The new gender identity has been present for at least 12 months.
  - The member has a consistent, stable gender identity that is well documented by their treating providers, and when possible, lives as their affirmed gender in places where it is safe
to do so.

- The gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder) is not a symptom of another mental disorder.
- For those candidates without a medical contraindication, the candidate has undergone a minimum of 12 months of continuous hormonal therapy that is provided under the supervision of a licensed clinician.

Policy Issued By: Blue Cross Blue Shield of Minnesota

Policy Title: Gender Affirming Procedures for Gender Dysphoria

Breast Reconstruction:

Breast Surgery

- Mastectomy and creation of a male chest in female-to-male members may be considered MEDICALLY NECESSARY AND APPROPRIATE when the criteria in section I are met.
  - **NOTE:** Hormone therapy is not a prerequisite for mastectomy for female-to-male members. The Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People Version 7 from the WPATH state the following: "Chest surgery in FtM (female-to-male) patients could be carried out (before age of majority) preferably after ample time of living in the affirmed gender identity 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 identity, 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."
- Breast augmentation (e.g. implants/lipofilling) may be considered MEDICALLY NECESSARY AND APPROPRIATE in male-to-female members when criteria in section I are met.
  - **NOTE:** Hormone therapy is not a prerequisite for breast augmentation for male-to-female members. The Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People Version 7 from the WPATH state the following: "Although not an explicit criterion, it is recommended that MtF (male-to-female) patients 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."

- Documentation Requirements

  - One consultation letter must be provided to a health plan representative from a qualified mental health professional (as defined in section I). The letter must address ALL of the following:
    1. The member's gender identifying characteristics; and
    2. Results of the member's psychosocial assessment, including all diagnoses; and
    3. The duration of the mental health professional's relationship with the member including the type of evaluation and therapy or counseling to date; and
    4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery; and
    5. The member has been informed that WPATH Standards of Care refer to breast/chest and genital surgical treatments as "irreversible," and that reversal of breast/chest and genital surgical treatment are not eligible for coverage prior to providing informed consent for this surgery; and
6. A statement about the fact that informed consent has been obtained from the patient; and
7. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

Policy Issued By: Blue Cross Blue Shield of Montana

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;
- The capacity to make a fully informed decision and to consent for treatment;
- Been diagnosed with persistent, well-documented gender dysphoria;
- The required referrals prior to any surgery or related service(s):

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

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;
- The capacity to make a fully informed decision and to consent for treatment;
- Been diagnosed with persistent, well-documented gender dysphoria;
- The required referrals prior to any surgery or related service(s):

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

Policy Issued By: Blue Cross Blue Shield of North Dakota

Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

Gender affirmation surgery may be considered medically necessary when ALL of the following are met:

- The individual is greater than or equal to 18 years of age; and
- The individual has the capacity to make a fully informed decision and to consent for treatment; and
- The individual has been diagnosed with the gender dysphoria, including ALL of the following:
  - The desire to live and be accepted as a member of another gender, usually accompanied by the wish to make their body as congruent as possible with the preferred sex through surgery and hormone treatment; and
  - The individual's transgender identity has been present persistently for at least six (6) months; and
  - The dysphoria is not a symptom of another mental disorder; and
  - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The individual is under the care of physicians and/or mental health providers who are able to document ALL of the following conditions:
  - For chest surgery (mastectomy and chest reconstruction)
    - Initiation of hormonal therapy (unless medically contraindicated or individual is unable or unwilling to take hormones); and
    - One referral from a qualified mental health professional with written documentation submitted to the physician performing the breast surgery; and
  - For hysterectomy and salpingo-oopherectomy, orchiectomy:
    - Documentation of at least 12 months of continuous hormonal sex reassignment therapy, (unless medically contraindicated or individual is unable or unwilling to take hormones); and
  - For vaginoplasty, phalloplasty, metoidioplasty:
    - The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender; and
Documentation of at least 12 months of continuous hormonal sex reassignment therapy, (unless medically contraindicated or individual is unable or unwilling to take hormones); and

Separate evaluation by the physician performing the genital surgery; and

The individual must complete a psychological evaluation performed by a licensed mental health care professional and be recommended for. The individual's medical record documentation should indicate that all psychosocial issues have been identified and addressed.

When ALL of the above criteria are met, the following breast/genital surgeries may be considered medically necessary:

Feminization procedures:

- Breast augmentation
- Orchietomy
- Clitoroplasty
- Colovaginoplasty
- Labiaplasty
- Orchietomy
- Penectomy
- Vaginoplasty

Note: Although not a requirement, it is recommended that individuals 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.

Masculinization procedures:

- Breast reconstruction (e.g., mastectomy)
- Colpectomy/Vaginectomy
- Hysterectomy
- Metoidioplasty
- Penile prosthesis
- Phalloplasty
- Reduction mammoplasty
- Salpingo-oophorectomy
- Scrotoplasty
- Testicular prosthesis implantation
- Urethroplasty

Policy Issued By: Blue Cross Blue Shield of Rhode Island

Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

Breast Augmentation Note: augmentation mammoplasty (including breast prosthesis if necessary) if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role

Policy Issued By: Blue Cross Blue Shield of South Carolina

Policy Title: Gender Reassignment Surgery
Breast Reconstruction:

When a benefit for gender reassignment surgery exists, it is considered a covered service when the documentation submitted confirms that all of the following eligibility criteria are met:

- The individual is at least 18 years of age, AND
- The individual has been diagnosed with the gender dysphoria based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders, AND
- The individual initially has successfully lived and worked within the desired gender role full-time for at least 12 months (real-life experience) without returning to the original gender, AND
- In addition to living and working with the desired gender role full-time for a minimum of 12 months, a minimum of an additional 12 continuous months of hormone replacement therapy must occur, AND
- After the minimum of 24 continuous months of living and working within the desired gender role full-time and hormone replacement therapy, the individual should undergo repeat comprehensive independent behavioral health evaluation.
- Regular psychotherapy and counseling should be available through the member's individualized gender reassignment pathway.

When a covered benefit for gender reassignment surgery exists and all of the above eligibility criteria are met, the following surgeries are Medically Necessary for transwomen (male to female):

Breast Augmentation (19324-19325) Note: augmentation mammoplasty (including breast prosthesis if necessary) if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role

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: BridgeSpan Health

Policy Title: Gender Affirming Interventions for Gender Dysphoria

Breast Reconstruction:

Gender affirming surgical interventions for gender dysphoria may be considered medically necessary when both of the following criteria are met (A - B):

A. All of following general criteria are met (1 - 5):

1. Age at least 18 years (Note: age requirement will not be applied to mastectomy with documented provider determination of medical necessity of earlier intervention); an
2. Clinical records document that the patient has the capacity to make fully informed decisions and consent for intervention, and that any other mental health condition, if present, is adequately controlled; and
3. At least 2 licensed mental health professionals have diagnosed gender dysphoria, and recommend surgical intervention (Note: only 1 mental health professional referral is required for mastectomy); and
4. Documentation of continuous hormonal therapy for at least 12 months, unless there is a documented contraindication to hormonal therapy (Notes: hormonal therapy is not required prior to mastectomy or breast augmentation; hormonal therapy for at least 6 months is required for endometrial ablation); and
5. At least 12 months of living in a role that is congruent with the patient’s

B. One or more of the following criteria are met: Clinical documentation is submitted expressly documenting that the intervention would improve otherwise documented significant gender dysphoria and the request is for one or more of the following procedures:

Breast augmentation
Policy Issued By: California

Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

Additional surgeries may be proposed (i.e., body feminization or masculinization) for an individual who is planning to undergo or has undergone gender reassignment surgery. Including, but not limited to, the following surgical procedures need to be reviewed for medical necessity (see documentation needed for medical necessity determination in the Policy Guidelines section):

• Breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast

Policy Issued By: Capital BlueCross

Policy Title: GENDER AFFIRMING SURGERY (FORMERLY REASSIGNMENT SURGERY FOR GENDER DYSPHORIA)

Breast Reconstruction:

The individual participates in trans-gender counseling and meets all of the following:

When ALL of the above criteria are met for gender reassignment surgery, the following genital surgeries may be considered medically necessary for transwomen (male to female):

• 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.

Policy Issued By: CareFirst BlueCross BlueShield

Policy Title: Gender Affirmation Services /Gender Dysphoria

Breast Reconstruction:

1. The individual is age 18 years or older; and
2. The individual has a confirmed diagnosis of gender dysphoria including all the following: ...
3. For those without a medical contraindication to hormonal therapy, the individual has undergone a minimum of 12 continuous months of hormonal therapy that was recommended by a mental health professional and supervised by a physician over the entire 12-month period; and
4. Documentation that the individual has completed a minimum of 12 months of successful continuous full-time, real-life experience in their desired gender, across a wide span of life experiences and events that may occur throughout the year (i.e., holidays, vacations, season-specific school and/or work experience, family events) ...
5. The individual has received the following referrals for surgery: One letter of referral from a licensed mental health professional, if the individual is seeking breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty)

The gender reassignment surgeries that may be performed for transwomen (male to female) that meet the above 5 criteria include but are not limited to: ... Mammoplasty: breast augmentation
Policy Issued By: CareSource

Policy Title: Gender Dysphoria (Georgia 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 (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 (Kentucky 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 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

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**Policy Issued By:** CareSource

**Policy Title:** Gender Dysphoria (West Virginia 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

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**Policy Issued By:** Cigna

**Policy Title:** Treatment of Gender Dysphoria

**Breast Reconstruction:**

The procedures listed below are considered medically necessary under standard benefit plan language when the above listed criteria for gender reassignment surgery have been met, unless specifically excluded in the benefit plan language: ...

Initial breast reconstruction including augmentation with implants

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**Policy Issued By:** EmblemHealth - New York

**Policy Title:** Gender Affirming/Reassignment Surgery - New York

**Breast Reconstruction:**

Gender affirming/reassignment surgery will be covered for members greater than or equal to 18 years of age.

The request must be accompanied by letters from two qualified New York State (NYS) licensed health professionals, acting within the scope of his/her practice, who have independently assessed the member and are referring the member for the surgery. (Note: Only one letter is required for breast surgery)

One letter must be from a psychiatrist, psychologist, psychiatric nurse practitioner (NP) or licensed clinical social worker (CSW) with whom the member has an established and ongoing relationship.

The other letter may be from a psychiatrist, psychologist, physician, psychiatric NP or licensed CSW who has only an evaluative role with the member.

Together, the letters must establish that the member:

1. Has a persistent and well-documented case of gender dysphoria
2. Has received hormone therapy (not prerequisite for mastectomy) appropriate to member's gender goals for a minimum of 12 months prior to seeking genital surgery (unless medically contraindicated or the member is otherwise unable to take hormones)
3. Has lived 12 months in gender role congruent with member's gender identity (inclusive of binary and Nonbinary Gender) and has received mental health counseling, as deemed medically necessary, during that time (Note: Not required for breast surgery)
4. Has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so, that those are reasonably well-controlled prior to the gender reassignment surgery
5. Has the capacity to make fully informed decisions and consent to treatment

Breast augmentation is considered medically necessary provided that 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 member is otherwise unable to take hormones.

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**Policy Issued By:** Empire Blue Cross Blue Shield (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.

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**Policy Issued By:** Excellus Blue Cross Blue Shield

**Policy Title:** Gender Reassignment/Gender Affirming Surgery and Treatments

**Breast Reconstruction:**

Based on our criteria and assessment of peer-reviewed literature, breast augmentation/implants, including nipple/areola reconstruction and tattooing, for transitioning individuals who were assigned male at birth, has been shown to be a beneficial and effective intervention for gender dysphoria, and, therefore, is considered medically appropriate when ALL of all the following criteria are met:
A. The patient has received a recommendation letter from a qualified mental health professional (refer to Policy Guidelines below); and

B. The patient has been diagnosed with persistent gender dysphoria, including all of the following:

1. The desire to live and be accepted as a member of the identified gender, usually accompanied by the wish to make their body as congruent as possible with the preferred gender through surgery and hormone treatment; and
2. The gender dysphoria has been present persistently for at least one year; and
3. The condition is not a symptom of another mental disorder or a chromosomal abnormality; and
4. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

C. The patient has the capacity to make a fully informed decision and to consent to treatment, as well as the ability to comply with all aftercare instructions, including recommended medical, surgical, nursing, and/or psychological care recommended by the individual’s providers; and

D. The patient has reached the age of majority (18 years of age or older); and

E. If significant medical or mental health concerns are present, they must be reasonably well controlled; and

F. The patient has completed a minimum of 24 months of hormone therapy, unless hormone therapy is medically contraindicated, or the patient is otherwise unable to take hormones.

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
C. The Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months isn't sufficient for comfort in the social role.

D. Color photograph front and side view

Policy Issued By: Geisinger Health Plan
Policy Title: Gender Dysphoria and Gender Confirmation Treatment

Breast Reconstruction:

Gender confirming services may be considered medically necessary when supporting documentation is provided by the clinicians (physicians and mental health professionals) confirms ALL of the following:

- The member is 18 years of age or older *
- The member has been diagnosed with Gender Dysphoria; and
- The member has expressed a desire to transition his/her body to the preferred gender through surgery and hormone replacement therapy** (if not otherwise contraindicated); and
- The member has completed a psychological assessment (psychotherapy may be recommended, but is not required) by a behavioral health professional with a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) who is capable of adequately evaluating if the candidate has any co-morbid psychiatric conditions; and;
- A medical evaluation has been completed by a MD/DO; and
- The gender confirming surgery has been recommended by:
  - One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty)"
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: Health Net
Policy Title: Gender Affirming Procedures

Breast Reconstruction:

A. Age > 18
   a. Exception: in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment;

B. Persistent, well-documented gender dysphoria with evidence the member has lived at least 12 continuous months in a gender role that is congruent with their gender identity (not required for mastectomy in female to male except for those < 18 years);

C. Capacity to make a fully informed decision and to consent for treatment;

D. If significant medical or mental health concerns are present, they must be reasonably well controlled;

E. Written referral letter(s) from a qualified mental health practitioner (See below for qualifications) based on the type of surgery (one referral for chest surgery; two referrals for genital surgery) and containing the following:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

7. The degree to which the member has followed the standards of care to date and the likelihood of future compliance
8. For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient’s chart.

Note: Although not an explicit criterion, it is recommended that male to female individuals 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.

It is the policy of Health Net of California that each of the following procedures, when used specifically to improve the appearance of an individual undergoing gender reassignment surgery or actively participating in a documented gender reassignment surgery treatment plan, must be evaluated to determine if it is medically necessary reconstructive surgery to create a normal appearance for the gender with which the member identifies. Prior to making a clinical determination of coverage, it may be necessary to consult with a qualified and licensed mental health professional and the treating surgeon. ... Breast augmentation

Policy Issued By: HealthPartners
Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

1. All of the following criteria must be met prior to mastectomy for female to male members or breast augmentation for male to female members:
   1. The member must:
      1. Have persistent, well documented gender dysphoria; and
      2. Have the capacity to make a fully informed decision and to consent for treatment; and
      3. Have one referral from a qualified mental health professional that addresses all of the following:
         1. The member’s general identifying characteristics; and
         2. Results of the member’s psychosocial assessment, including any diagnoses; and
         3. The duration of the mental health professional’s relationship with the member including the type of evaluation and therapy or counseling to date; and
         4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member’s request for surgery; and
         5. A statement that informed consent has been obtained from the patient; and
         6. A statement that the mental health professional is available for coordination of care.
   2. If significant medical or mental health concerns are present, documentation must support that they are reasonably well controlled.

Please note: Hormone therapy is not a prerequisite to mastectomy or breast augmentation.

Policy Issued By: Highmark Blue Cross Blue Shield Delaware
Policy Title: Gender Affirmation Surgery

Breast Reconstruction:
Gender affirmation surgery may be considered medically necessary when **ALL** of the following are met:

- The individual is greater than or equal to 18 years of age; **and**
- The individual has the capacity to make a fully informed decision and to consent for treatment; **and**
- The individual has been diagnosed with the gender dysphoria, including **ALL** of the following:
  - The desire to live and be accepted as a member of another gender, usually accompanied by the wish to make their body as congruent as possible with the preferred sex through surgery and hormone treatment; **and**
  - The individual’s transgender identity has been present persistently for at least six (6) months; **and**
  - The dysphoria is not a symptom of another mental disorder; **and**
  - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The individual is under the care of physicians and/or mental health providers who are able to document **ALL** of the following conditions:
  - For chest surgery (mastectomy and chest reconstruction)
    - Initiation of hormonal therapy (unless medically contraindicated or individual is unable or unwilling to take hormones); **and**
    - One referral from a qualified mental health professional with written documentation submitted to the physician performing the breast surgery;

When **ALL** of the above criteria are met, the following breast/genital surgeries may be considered medically necessary:

**Feminization procedures:**

**Breast augmentation**

**Note:** Although not a requirement, it is recommended that individuals 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.

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**Policy Issued By:** Highmark Blue Cross Blue Shield (Pennsylvania)

**Policy Title:** Gender Affirmation Surgery

**Breast Reconstruction:**

GRS may be considered medically necessary when **ALL** of the following are met:

- The individual is greater than or equal to 18 years of age; and
- The individual has the capacity to make a fully informed decision and to consent for treatment; and
- The individual has been diagnosed with the gender dysphoria of transsexualism, including **ALL** of the following:
  - 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
  - The individual’s transsexual identity has been present persistently for at least two (2) years; and
  - The disorder is not a symptom of another mental disorder or a chromosomal abnormality; and
The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- The individual is an active participant in a recognized gender identity treatment program and demonstrates ALL of the following conditions:
  - The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender; and
  - Initiation of hormonal therapy or breast surgery recommended by a qualified health professional with written documentation submitted to the physician responsible for the medical treatment; and
  - Documentation of at least 12 months of continuous hormonal sex reassignment therapy, unless medically contraindicated (may be simultaneous with real life experience); and
  - Recommendation for sex reassignment surgery by two (2) qualified mental health professionals who recommend sex reassignment surgery with written documentation submitted to the physician performing the genital surgery*; and
  - Separate evaluation by the physician performing the genital surgery.

* At least one (1) letter must be a comprehensive report. Two (2) separate letters or one (1) letter with two (2) signatures is acceptable. One (1) letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. (clinical psychologist).

When ALL of the above criteria are met, the following breast/genital surgeries may be considered medically necessary:

Feminization procedures:

Breast augmentation

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Policy Issued By: Highmark West Virginia

Policy Title: Gender Affirmation Surgery

Breast Reconstruction:

Gender affirmation surgery may be considered medically necessary when ALL of the following are met:

- The individual is greater than or equal to 18 years of age; and
- The individual has the capacity to make a fully informed decision and to consent for treatment; and
- The individual has been diagnosed with the gender dysphoria, including ALL of the following:
  - The desire to live and be accepted as a member of another gender, usually accompanied by the wish to make their body as congruent as possible with the preferred sex through surgery and hormone treatment; and
  - The individual's transgender identity has been present persistently for at least six (6) months; and
  - The dysphoria is not a symptom of another mental disorder; and
  - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
The individual is under the care of physicians and/or mental health providers who are able to document ALL of the following conditions:

- For chest surgery (mastectomy and chest reconstruction)
  a. Initiation of hormonal therapy (unless medically contraindicated or individual is unable or unwilling to take hormones); and
  b. One referral from a qualified mental health professional with written documentation submitted to the physician performing the breast surgery; and

- For hysterectomy and salpingo-oopherectomy, orchiectomy:
  a. Documentation of at least 12 months of continuous hormonal sex reassignment therapy, (unless medically contraindicated or individual is unable or unwilling to take hormones); and

- For vaginoplasty, phalloplasty, metoidioplasty:
  a. The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender; and
  b. Documentation of at least 12 months of continuous hormonal sex reassignment therapy, (unless medically contraindicated or individual is unable or unwilling to take hormones); and
  c. Separate evaluation by the physician performing the genital surgery; and
  d. The individual must complete a psychological evaluation performed by a licensed mental health care professional and be recommended for. The individual's medical record documentation should indicate that all psychosocial issues have been identified and addressed.

**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.)*

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**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.

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**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.

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**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: Johns Hopkins Healthcare
Policy Title: Gender Affirmation Treatment & Procedures
Breast Reconstruction:

Breast/Chest Surgery: When benefits are provided under the member's contract, JHHC will
authorize gender reassignment breast/chest surgery when ALL of the following criteria are
met:

a. One letter of referral (letter of medical necessity) from a licensed mental health
   professional, AND

b. Persistent, well-documented gender dysphoria, AND

c. Capacity to make fully informed decisions and consent for treatment, AND;

d. The member has reached the legal age of medical consent, AND

e. If significant medical or mental health issues present, they must be sufficiently (reasonably
   well) controlled

f. Female-to-male breast/chest surgery does not require hormone therapy as a pre-requisite
   for the covered procedures noted in section E. 1. a. below.

g. Male-to-female breast/chest surgery is covered when ALL of the following have been met
   for the covered procedure noted in section E. 1. c. below:
i. Breast size measures less than Tanner stage 5 after undergoing 12 months of hormone therapy, AND

ii. Breast size continues to cause clinically significant distress in social, occupational, or other areas of functioning as documented by a qualified mental health provider as identified in section.

Policy Issued By: Kaiser Foundation Health Plan of Washington

Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

Requirements for breast augmentation for male-to-female members:

A. Single letter of referral from a qualified mental health professional; and

B. Persistent, well-documented gender dysphoria per DSM 5 Gender Dysphoria; and

C. Capacity to make a fully informed decision and to consent for treatment; and

D. Age 18 years or older (Note: age requirement will not be applied to augmentation in Male-to-Female patients if the surgeon, the primary care provider, and the qualified mental health professional unanimously document the medical necessity of earlier intervention)

E. If significant medical or mental health concerns are present, they must be reasonably well controlled. The health plan may require a second opinion regarding the patient's stability prior to surgery if in question; and

F. Twelve months of living in a gender role that is congruent with their gender identity (real life experience) and

G. Twelve months of continuous hormone therapy as appropriate to the member’s gender goals.

If the referring medical provider or mental health provider requests surgical intervention prior to the patient's completion of 12 months of hormone therapy and/or living in desired gender, the surgeon, the primary care provider, and the qualified mental health professional must submit evidence of medical necessity and clear rationale for the proposed surgical intervention to be done early. The three providers must submit written documentation to the plan that includes:

a. A comprehensive, coordinated treatment plan with evidence that all treatment plan criteria for surgery and treatment goals have been met; and

b. Clear rationale for the variation from either the 12-month period of hormone therapy and/or living for 12 months in desired gender; and

c. Patient understands the treatment plan, risks and benefits of surgery prior to completing the 12-month period; and

d. The plan will determine authorization and consent to care based on medical necessity from the documentation outlined in A-G above.

The criteria above apply for only initial male to female augmentation mammoplasty, any additional breast augmentation after an initial mammoplasty is considered a cosmetic procedure, and therefore, a contract exclusion.
Breast Reconstruction:

MtF members are eligible for Breast Augmentation if they meet all of the following criteria:

1. Single letter of referral from a qualified mental health professional; and
2. Persistent, well-documented gender dysphoria per DSM 5 Gender Dysphoria; and
3. Capacity to make a fully informed decision and to consent for treatment; and
4. Age 18 years or older (Note: age requirement will not be applied to augmentation in Male-to-Female patients if the surgeon, the primary care provider, and the qualified mental health professional unanimously document the medical necessity of earlier intervention); and
5. If significant medical or mental health concerns are present, they must be reasonably well controlled. The health plan may require a second opinion regarding the patient’s stability prior to surgery if in question; and
6. Twelve months of living in a gender role that is congruent with their gender identity (real life experience) and
7. Twelve months of continuous hormone therapy as appropriate to the member’s gender goals.

If the referring medical provider or mental health provider requests surgical intervention prior to the patient’s completion of 12 months of hormone therapy and/or living in desired gender, the surgeon, the primary care provider, and the qualified mental health professional must submit evidence of medical necessity and clear rationale for the proposed surgical intervention to be done early.

The three providers must submit written documentation to the plan that includes:

a. A comprehensive, coordinated treatment plan with evidence that all treatment plan criteria for surgery and treatment goals have been met; and
b. Clear rationale for the variation from either the 12-month period of hormone therapy and/or living for 12 months in desired gender; and
c. Patient understands the treatment plan, risks and benefits of surgery prior to completing the 12-month period.

The plan will determine authorization and consent to care based on medical necessity from the documentation outlined in 1-7 above. The criteria above apply for only initial male to female augmentation mammoplasty, any additional breast augmentation after an initial mammoplasty is considered a cosmetic procedure, and therefore, a contract exclusion.

NOTE: These criteria pertain to Washington Public Employee Benefit Board PEBB members only.

Breast augmentation will require prior-authorization utilizing the following coverage criteria

Diagnosis of gender dysphoria (male to female) AND
Has received at least 1 year of hormone therapy (unless there are contraindications) AND ONE:

- No measurable cup size growth, defined as less than an A cup, in one or both breasts
- Asymmetry where one breast did not have a measurable cup size growth, defined as less than an A cup.

Documentation from surgeon of current cup size and proposed changes as well as photo documentation.

- This policy pertains to Washington PEBB members only effective 1/1/17.
- OHP (Oregon Medicaid) see OHP Prioritized List, Guideline Note 127 for treatment of Gender Dysphoria.
- For all other groups, breast augmentation is not covered. See UR 65 Transgender Surgery UM Criteria for covered gender transition procedures.

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**Policy Issued By:** LifeWise

**Policy Title:** Gender Reassignment Surgery

**Breast Reconstruction:**

One recommendation letter within the last six months from a licensed mental health professional

The required minimum content of the recommendation letter:

- Document a comprehensive evaluation
  - Confirmation of the diagnosis of gender dysphoria or gender identity disorder
  - An assessment of the member's capacity to make a fully informed decision about proceeding with the surgery
  - Identification of any co-morbid psychiatric disorders or other mental health concerns with documentation that those are not influencing the individual's decision regarding surgery, are not contraindications to surgery, and are not likely to cause a negative psychiatric outcome after the surgery
  - Verification that the member's decision is current, is well thought out, is not impulsive, and is not due to any other potentially treatable mental disorder

Documentation from the surgeon that there are no medical contraindications to surgery

Augmentation mammaplasty for male to female patients

All of the above, plus, one of the following:

- Documentation of failure of breast growth stimulation by estrogen, specifically, progression to no more than a young adolescent stage of development OR
- Documentation of emergence of serious or intolerable adverse effects during estrogen administration OR
- Documentation of medical contraindication to use of estrogen OR
- Documentation of a risk-benefit analysis determining that surgery is preferable to estrogen therapy

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**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: Medica
Policy Title: Gender Reassignment Surgery

Breast Reconstruction:

Gender reassignment surgery is medically necessary when all of the following criteria are met (adapted from the World Professional Association for Transgender Health Inc., Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, (Seventh Version 2012):

A. The member must have a diagnosis of gender dysphoria from the Diagnostic and Statistical Manual of Mental Disorders [DSM 5-TR, 2013] section 302.6.

B. Eligibility criteria for specific surgeries:

1. Criteria for mastectomy for female to male
   a. The member has persistent, well-documented gender dysphoria
   b. The member is 18 years of age or older
   c. The member has the capacity to make a fully informed decision and to consent for treatment
   d. If significant medical or mental health concerns are present, documentation must support that they are reasonably well-controlled.

NOTE: Hormonal treatment is not a prerequisite for mastectomy.

2. Criteria for breast augmentation for male to female
   a. The member has persistent, well-documented gender dysphoria
   b. The member is 18 years of age or older
   c. The member has the capacity to make a fully informed decision and to consent for treatment
d. If significant medical or mental health concerns are present, documentation must support that they are reasonably well-controlled

e. Twelve months of continuous hormonal gender reassignment treatment must be completed.
Breast/chest surgery for Male-to-Female (MtF) members is medically appropriate with ALL of the following: (Hormone therapy is not a prerequisite)

a. One referral from qualified behavioral/mental health professional (See Appendix B for referral letter requirements)

b. Persistent, well-documented gender dysphoria

c. Age of majority (18 years of age or older)

d. If significant medical or mental health concerns are present, they must be reasonably well controlled.

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 or Member has successfully lived full-time in the desired gender role without returning 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 mammoplasty 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-ophorectomy
- 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.

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Policy Issued By: Palmetto
Policy Title: Gender Reassignment Services for Gender Dysphoria

**Breast Reconstruction:**

When all of the above criteria are met for gender reassignment surgery, the following genital surgeries may be considered for transwomen (male to female): Mammoplasty - breast augmentation

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Policy Issued By: Premera Blue Cross
Policy Title: Gender Reassignment Surgery

**Breast Reconstruction:**
Mastectomy for female to male patients and augmentation mammaplasty for male to female patients

- 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
  - Note: A trial of hormone therapy is not a prerequisite for qualifying for a mastectomy.
- For augmentation mammaplasty for male to female patients, one of the following:
  - 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.

Policy Issued By: Prestige Health Choice

Policy Title: Gender Dysphoria

Breast Reconstruction:

Candidate Criteria:

A. The member is an adult age 18 or older, or documented as an emancipated adolescent, or has documentation of appropriate consent from parent or guardian.

B. The member has the capacity to make fully informed decisions and consent for treatment.

C. The member has received a diagnosis of gender dysphoria by a qualified health professional.

The diagnosis must be based on:

1. Strong and persistent cross-gender identification. In adolescents and adults, the condition is manifested by symptoms such as a stated desire to be the other gender, frequent passing as the other gender, desire to live or be treated as the other gender, or the conviction that he or she has the typical feelings and reactors of the other gender.

2. Persistent discomfort (dysphoria) with his/her gender or sense of inappropriateness in the gender role of that sex.

3. The dysphoria is not concurrent with a physical intersex condition.

4. The dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The member desires to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his/her body conform as much as possible to the preferred sex through surgery and hormone treatment.

E. The member has had real-life experience of at least 12 months in his/her desired gender.
F. Gender dysphoria is not a symptom of another mental disorder.

**Referrals for Surgical Procedures**

One or more referrals from a qualified mental health professional are necessary for certain procedures, including:

A. Breast/chest surgery, including mastectomy, chest reconstruction, and augmentation mammoplasty (one letter).

B. Genital surgery, including hysterectomy, salpingo-oophorectomy, orchiectomy, and genital reconstruction (two letters, one from the member’s psychotherapist, one from a professional who had an evaluative role).

Referral letters should include member identification, results of psychosocial assessments, duration of practitioner relationship with the member, a statement explaining that the criteria for surgery have been met, a statement that the member has given informed consent, and a statement that the practitioner is available for coordination of care.

**Breast/Chest Surgery**

Breast augmentation and mastectomy for female to male (transmen) and creation of male chest for male to female (transwomen) members are considered medically necessary when the following criteria are met:

1. Persistent gender dysphoria is well documented.
2. Member has the capacity to make informed decisions and consent to treatment.
3. Member is of majority (adults only).
4. Any significant medical or mental health concerns are controlled.
5. Member has had at least 12 months of feminizing hormone therapy (recommended for breast augmentation).
6. One letter of referral is submitted

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**Policy Issued By:** Providence Health Plans and Providence Health Assurance

**Policy Title:** Gender Affirming Surgical Interventions

**Breast Reconstruction:**

Breast/Chest Surgery Mastectomy and Creation of a Male Chest

I. Mastectomy and creation of a male chest may be considered medically necessary and covered when all of the following (A.-E.) WPATH Standards of Care criteria are met:

A. Persistent, well-documented gender dysphoria; and

B. Capacity to make a fully informed decision and give consent for treatment; and

C. Patient has reached the legal age to give medical consent under applicable state law; and

D. If significant medical or mental health concerns are present, they must be reasonably well controlled; and

E. One (1) referral from a qualified mental health professional (see Policy Guidelines for the WPATH recommended qualifications for mental health professionals and content of the referral letters for surgery)

Note: Hormone therapy is not a prerequisite

II. Breast augmentation (implants/lipofilling) may be considered medically necessary and covered when all of the following (A.-E.) WPATH Standards of Care criteria are met:
A. Persistent, well documented gender dysphoria; and

B. Capacity to make a fully informed decision and to give consent for treatment; and

C. Patient has reached the legal age to give medical consent under applicable state law; and

D. If significant medical or mental health concerns are present, they must be reasonably well controlled; and E. One (1) referral from a qualified mental health professional (see Policy Guidelines for the WPATH recommended qualifications for mental health professionals and content of the referral letters for surgery)

**Policy Issued By:** Tufts Health Plan

**Policy Title:** Transgender Surgical Procedures

**Breast Reconstruction:**

Tufts Health Plan may authorize the coverage of transgender surgery procedures listed in this guideline for Members who have this benefit included in their plan document when ALL of the following criteria are met:

1. The Member 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
2. The Member has received continuous hormone therapy for 12 months or more under the supervision of a physician. Exceptions: The Member has a medical contraindication that is attested to by the treating endocrinologist; or when the request is mastectomy only for female to male surgery.
3. The Member has lived as their reassigned gender full-time for 12 months or more.
   (Numbers 2 and 3 may occur concurrently.)
4. The Member’s medical and mental health providers document that there are no contraindications to the planned surgery and agree with the plan (within three months of the Prior Authorization request).

When the above guidelines are met, Tufts Health Plan may authorize one or more of the following covered surgeries, up to the Member’s benefit limit: .. Mammaplasty (breast augmentation)

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**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: UnitedHealthcare

Policy Title: Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9) (Medicare Advantage)

Breast Reconstruction:

Listing CPT 19325 Mammaplasty, augmentation; with prosthetic implant

In the absence of an NCD, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

Policy Issued By: UnitedHealthcare of California

Policy Title: Gender Dysphoria (Gender Identity Disorder) Treatment (California)

Breast Reconstruction:

Surgical treatment for Gender Dysphoria is covered when the Eligibility Qualifications for Surgery are met:

2. Surgery to change specified secondary sex characteristics, specifically:

Augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

Clarifications for breast/chest surgery:

In addition to the Eligibility Qualifications listed above note the following:

A biologic male member that is only requesting a breast augmentation:

• If able to take female hormones, the member should take the female hormones for at least 12-24 months* before being considered for bilateral breast augmentation since the member may achieve adequate breast development without surgery.
• Although not a requirement for coverage, UnitedHealthcare recommends that the member complete at least 3 months of psychotherapy before having the breast augmentation.

*12 months is listed by WPATH v7, whereas, 2 years is listed by, Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009).

Policy Issued By: UnitedHealthcare West

Policy Issued By: UnitedHealthcare

Policy Issued By: UnitedHealthcare of California

Policy Issued By: UnitedHealthcare West
Policy Title: Gender Dysphoria (Gender Identity Disorder) Treatment (Oregon)

Breast Reconstruction:

Coverage is available for medical, behavioral or pharmacological treatment that is Medically Necessary for Gender Dysphoria. UnitedHealthcare does not exclude or deny covered health care benefits based on associated diagnosis of Gender Dysphoria, or otherwise discriminate against the member on the basis that treatment is for Gender Dysphoria.

Policy Issued By: UnitedHealthcare West

Policy Title: Gender Dysphoria (Gender Identity Disorder) Treatment (Washington)

Breast Reconstruction:

Coverage is available for medical, behavioral or pharmacological treatment that is Medically Necessary for Gender Dysphoria. UnitedHealthcare does not exclude or deny covered health care benefits based on associated diagnosis of Gender Dysphoria, or otherwise discriminate against the member on the basis that treatment is for Gender Dysphoria.

Policy Issued By: UnitedHealthcare West

Policy Title: Gender Dysphoria Treatment Excluding California and Washington (Oklahoma, Oregon, Texas)

Breast Reconstruction:

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outline below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Policy Issued By: Univera Healthcare

Policy Title: Gender Reassignment/Gender Affirming Surgery and Treatments for Medicaid Managed Care Plan (MMCP) and Health and Recovery Plan (HARP) Members

Breast Reconstruction:

I. Based on our assessment of peer-reviewed literature, hormone therapy, whether or not in preparation for gender reassignment surgery, has shown to be a beneficial and effective intervention for gender dysphoria, and is considered medically appropriate as follows:

A. Treatment with gonadotropin-releasing hormone agents (pubertal suppressants), based upon a determination by a qualified medical professional that an individual is eligible and ready for such treatment, i.e., that the individual:

1. Meets the criteria for a diagnosis of gender dysphoria;
2. Has experienced puberty to at least Tanner stage 2, and pubertal changes have resulted in an increase in gender dysphoria;
3. Does not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment;
4. Has adequate psychological and social support during treatment; and
5. Demonstrates knowledge and understanding of the expected outcomes of treatment with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment.

B. Treatment with cross-sex hormones for patients who are 16 years of age and older, based upon a determination by a qualified medical professional that such treatment is medically necessary.

1. Patients who are under 18 years of age must meet only the applicable criteria stated in Policy Statement I.A.1-5. above.

2. Payment for cross-sex hormones for patients under 16 years of age who otherwise meet the requirements stated in Policy Statement I.A.1-5., shall be made in specific cases if medical necessity is demonstrated by a qualified medical professional and prior approval is received.

3. New York State (NYS) Medicaid reimbursement is only available for conjugated estrogens, estradiol, and testosterone cypionate, and testosterone topical gel 1.62 percent (Androgel).

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Policy Issued By: University Health Alliance
Policy Title: Gender Identity Services

Breast Reconstruction:

The following services are considered cosmetic and do not meet criteria for medical necessity:

Coverage exceptions can be requested for review on an individual basis. ... breast enlargement procedures such as augmentation mammoplasty and implants

__________________________________________________________
Policy Issued By: UPMC Health Plan
Policy Title: Gender Affirmation Surgery

Breast Reconstruction:

Gender affirmation surgery involving feminizing breast/chest surgery is considered medically necessary and covered when all of the criteria below are met:

1. A persistent, well-documented diagnosis of gender dysphoria (as outlined in the Definitions Section), including all of the following indications:
   ◦ The desire to live and be accepted as a person whose gender is different than that 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
   ◦ The desire for alternate gender identity has been present for at least 6 months; and
   ◦ The gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning; and

2. The mental capacity for fully-informed consent as outlined in the Definitions Section; and
3. A minimum of 12 months of continuous hormonal therapy, as recommended, as appropriate to the patient’s gender goals (unless the patient has a medical contraindication or is otherwise unable to take hormones).
4. If significant medical or mental health issues are present, they must be reasonably well-controlled.

   • One referral from a qualified mental health professional (see Definitions Section) who has independently assessed the patient.

*Medicaid plans: For feminizing breast/chest surgery, patients younger than 18 years of age will be reviewed by a Medical Director.

**Information Required for Review**

In order to determine medical necessity for covered gender affirmation surgical procedures, adequate information must be furnished by the treating physician. Required documentation includes all of the following:

1. Letter of medical necessity including documentation of the following:

   Date of birth

   • Diagnosis of persistent well-documented gender dysphoria according to DSM-V criteria as defined above
   • Capacity to provide fully-informed consent

2. Progress notes showing clear documentation of the experience in the gender role including the start date of living full time in the gender role. Notes must reflect the above listed appropriate number of months of living full time in a gender role that is congruent with their gender identity (if applicable).

3. Documentation of type(s) of hormonal therapy used, including dates of initiation and discontinuation (if applicable).

4. Documentation of breast size after 12 months of hormone therapy for MtF (if applicable).

5. Documentation that fully informed consent for the requested surgery was obtained.

6. Documentation (if applicable) of the presence and nature of any significant medical or mental health conditions, and documentation that they are reasonably well-controlled.

7. Documentation of one referral from qualified mental health professionals (see Definitions Section) who have independently assessed the patient.

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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 mammoplasty 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 mammoplasty.

Additional breast augmentation after an initial augmentation mammoplasty 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.)