Facial Reconstruction

These are a list of clinical criteria that have explicit coverage for facial feminization for transgender women, and in some cases, facial masculinization for transgender men.

Policy Issued By: Amerigroup (Anthem)

Policy Title: Gender Affirming Surgery

Facial Reconstruction:

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

1. The individual is at least 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. 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
5. 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
6. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; and
7. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and
8. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

†See Discussion section for a list of procedures included in this group of procedures
Facial Reconstruction:

Requires supporting documentation that indicates specific type of FFS procedures requested.

Policy Issued By: Anthem
Policy Title: Gender Affirming Surgery

Facial Reconstruction:

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

1. The individual is at least 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. 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
5. 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
6. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; and
7. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and
8. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

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

Policy Issued By: Anthem Blue Cross (California)
Policy Title: Gender Affirming Surgery

Facial Reconstruction:

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

1. The individual is at least 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. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when

Policy Issued By: Anthem Blue Cross (California)
Policy Title: Gender Affirming Surgery

Facial Reconstruction:

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

1. The individual is at least 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. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy when
5. 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
6. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; and
7. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and
8. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

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

The following procedures are considered cosmetic and not a covered benefit include, but are not limited to:

- Feminizing procedures including Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction of hyoid (chondroplasty), hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing.

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Policy Issued By: BlueChoice Healthplan of South Carolina

Policy Title: Gender Affirming Surgery

Facial Reconstruction:

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

1. The individual is at least 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. 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
5. 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
6. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; and
7. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and
8. 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: Blue Cross Blue Shield of Illinois

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

Facial Reconstruction:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered medically necessary for the treatment of gender dysphoria ONLY. These procedures may include the following:

- Blepharoplasty;
- Brow lift;
- Cheek implants;
- Chin or nose implants;
- Face lift (rhytidectomy);
- Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
- Forehead lift or contouring;
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
- Laryngoplasty;
- Lip reduction or lip enhancement;
- Neck tightening;
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
- Rhinoplasty (nose correction)
- Skin resurfacing

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**Policy Issued By:** Blue Cross Blue Shield of Massachusetts

**Policy Title:** Gender Affirming Services (Transgender Services)

**Facial Reconstruction:**

Facial feminization or masculinization may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:

- Age ≥ 18
- The member 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 should be 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.
- Covered procedures when medical necessity criteria are met:
  - Forehead contouring
  - Rhinoplasty
  - Mandible reconstruction
  - Trachea shave
  - Blepharoplasty
  - Brow lift
  - Cheek augmentation
  - Face lift or liposuction (only as needed in conjunction with one of the above procedures).
- The following facial procedures are considered INVESTIGATIONAL and are not covered:
  - Lip enhancement
  - Neck lift
  - Dermabrasion
  - Chemical peel
  - Hair transplant
  - Electrolysis (except for genital surgery as noted below)
○ Vocal cord surgery.

**Policy Issued By:** Blue Cross Blue Shield of Minnesota

**Policy Title:** Gender Affirming Procedures for Gender Dysphoria

**Facial Reconstruction:**

The following procedures for the treatment of gender dysphoria may be considered **MEDICALLY NECESSARY AND APPROPRIATE** to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment treatment plan when criteria in section I are met:

- Electrolysis or laser treatment for facial hair removal;
- Voice therapy;
- Voice modification surgery when voice/speech therapy has been ineffective;
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
- Facial feminization or masculinization surgery on a case-by-case basis, including the following procedures:
  - Hairline advancement;
  - Forehead contouring/reconstruction;
  - Implant augmentation/reduction of the forehead and brow;
  - Blepharoplasty;
  - Brow lift;
  - Cheek augmentation with implants or autologous fat grafting;
  - Rhinoplasty;
  - Upper lip lift;
  - Lip augmentation with tissue augmentation or fat graft;
  - Implant augmentation/reduction of the mandible and chin;
  - Neck lift;
  - Face lift or liposuction (only as needed in conjunction with the above facial procedures).

**Policy Issued By:** Blue Cross Blue Shield of Montana

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

**Facial Reconstruction:**

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered **medically necessary for the treatment of gender dysphoria ONLY.** These procedures may include the following:

- Blepharoplasty;
- Brow lift;
- Cheek implants;
- Chin or nose implants;
- Face lift (rhytidectomy);
- Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
- Forehead lift or contouring;
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
- Laryngoplasty;
- Lip reduction or lip enhancement;
• Neck tightening;
• Reduction thyroid chondroplasty or trachea shaving (reduction of Adam’s apple);
• Rhinoplasty (nose correction)
• Skin resurfacing

Facial Reconstruction:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered medically necessary for the treatment of gender dysphoria ONLY. These procedures may include the following:

• Blepharoplasty;
• Brow lift;
• Cheek implants;
• Chin or nose implants;
• Face lift (rhytidectomy);
• Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
• Forehead lift or contouring;
• Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
• Laryngoplasty;
• Lip reduction or lip enhancement;
• Neck tightening;
• Reduction thyroid chondroplasty or trachea shaving (reduction of Adam’s apple);
• Rhinoplasty (nose correction)
• Skin resurfacing

Facial Reconstruction:

Surgical procedures

The following surgical procedures may be considered medically necessary if the above general criteria have been met AND the procedures are being performed only as a part of the overall treatment plan for gender dysphoria:

3. Facial procedures for facial feminization or masculinization:

Blepharoplasty • Brow lift • Cheek/malar implants • Chin contouring and implants • Face lift (only if done as necessary in conjunction with other facial procedures) • Facial bone osteoplasty • Forehead reduction and contouring • Mandible reduction, contouring, augmentation • Rhinoplasty

Facial Reconstruction:

Surgical procedures

The following surgical procedures may be considered medically necessary if the above general criteria have been met AND the procedures are being performed only as a part of the overall treatment plan for gender dysphoria:

3. Facial procedures for facial feminization or masculinization:

Blepharoplasty • Brow lift • Cheek/malar implants • Chin contouring and implants • Face lift (only if done as necessary in conjunction with other facial procedures) • Facial bone osteoplasty • Forehead reduction and contouring • Mandible reduction, contouring, augmentation • Rhinoplasty

Policy Issued By: Blue Cross Blue Shield of New Mexico
Policy Title: Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Policy Issued By: Blue Cross Blue Shield of North Carolina
Policy Title: Gender Confirmation Surgery and Hormone Therapy

Policy Issued By: Blue Cross Blue Shield of Oklahoma
Policy Title: Gender Assignment Surgery and Gender Reassignment Surgery with Related Services
Facial Reconstruction:

F. Secondary Sexual Characteristic (Masculinizing or Feminizing) Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered medically necessary for the treatment of gender dysphoria ONLY. These procedures may include the following:

- Abdominoplasty;
- Blepharoplasty;
- Brow lift;
- Calf implants;
- Cheek implants;
- Chin or nose implants;
- External penile prosthesis (vacuum erection devices);
- Face lift (rhytidectomy);
- Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
- Forehead lift or contouring;
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
- Laryngoplasty;
- Lip reduction or lip enhancement;
- Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;
- Neck tightening;
- Pectoral implants;
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
- Redundant/excessive skin removal;
- Rhinoplasty (nose correction);
- Skin resurfacing;
- Testicular expanders;
- Voice modification surgery; and/or
- Voice (speech) therapy or voice lessons.

NOTE 4: Preparatory or ancillary procedures (such as anesthesia, tissue harvesting for skin, fat, nerve or muscle grafting, etc.) and supplies or equipment (such as stents, prosthesis, implants, etc.) that are required for the procedures listed above are considered an integral part of the MtF or FtM transition process.

NOTE 5: Surgical repairs or revisions related to MtF or FtM procedures may be required, such as removal and replacement of prostheses.

Policy Issued By: Blue Cross Blue Shield of Rhode Island

Policy Title: Gender Reassignment Surgery

Facial Reconstruction:

Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage (31899)

Policy Issued By: BlueCross BlueShield of South Carolina

Policy Title: Gender Reassignment Surgery
Facial Reconstruction:

Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage (31899)

Policy Issued By: Blue Cross Blue Shield of Texas

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

Facial Reconstruction:

F. Secondary Sexual Characteristic (Masculinizing or Feminizing) Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered medically necessary for the treatment of gender dysphoria ONLY. These procedures may include the following:

• Abdominoplasty;
• Blepharoplasty;
• Brow lift;
• Calf implants;
• Cheek implants;
• Chin or nose implants;
• External penile prosthesis (vacuum erection devices);
• Face lift (rhytidectomy);
• Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
• Forehead lift or contouring;
• Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
• Laryngoplasty;
• Lip reduction or lip enhancement;
• Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;
• Neck tightening;
• Pectoral implants;
• Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
• Redundant/excessive skin removal;
• Rhinoplasty (nose correction);
• Skin resurfacing;
• Testicular expanders;
• Voice modification surgery; and/or
• Voice (speech) therapy or voice lessons.

NOTE 4: Preparatory or ancillary procedures (such as anesthesia, tissue harvesting for skin, fat, nerve or muscle grafting, etc.) and supplies or equipment (such as stents, prosthesis, implants, etc.) that are required for the procedures listed above are considered an integral part of the MtF or FtM transition process.

NOTE 5: Surgical repairs or revisions related to MtF or FtM procedures may be required, such as removal and replacement of prostheses.
Facial Reconstruction:

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

1. The individual is at least 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. 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
5. 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
6. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; and
7. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and
8. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

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

Policy Issued By: Blue Cross of Idaho

Policy Title: Gender Reassignment

Facial Reconstruction:

THE FOLLOWING PROCEDURES ARE CONSIDERED COSMETIC AS THEY ARE PRIMARILY INTENDED TO ENHANCE APPEARANCE, AND THEREFORE NOT ELIGIBLE FOR COVERAGE AS A TREATMENT FOR GENDER DYSPHORIA:

1. Abdominoplasty
2. Blepharoplasty
3. Breast augmentation (except as outlined above WITH a documented diagnosis of gender dysphoria)
4. Breast reduction/mastectomy (except as outlined above WITH a documented diagnosis of gender dysphoria). a. See also 1) BCI MP 7.01.21 Reduction Mammaplasty for Breast-Related Symptoms 2) BCI MP 7.01.13 Surgical Treatment of Bilateral Gynecomastia
5. Brow lift
6. Calf implants
7. Electrolysis
8. Face lift
9. Facial bone reconstruction, reduction, or enhancement
10. Facial implants
11. Glansplasty
12. Gluteal augmentation
13. Hair removal/hairplasty (EXCEPT for approved neovagina or vaginoplasty)
14. Jaw reduction (jaw contouring)
15. Lip reduction/enhancement
16. Lipofilling/collagen injections
17. Liposuction
18. Nose implants
19. Pectoral implants
20. Rhinoplasty
21. Thyroid cartilage reduction (chondrolaryngoplasty)
22. Voice modification surgery
23. Voice therapy

Policy Issued By: California
Policy Title: Gender Reassignment Surgery

Facial 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):

- Blepharoplasty/Brow reduction/brow lift (removal of redundant skin of the upper and/or lower eyelids and protruding periorbital fat)
- Chin augmentation (reshaping or enhancing the size of the chin)
- Chin/nose/cheek implants
- Face lift/forehead lift (e.g., rhytidectomy)
- Facial reconstruction for feminization or masculinization (e.g., facial bone reduction)
- Forehead augmentation
- Hair reconstruction (hair removal/hair transplantation)
- Jaw/mandibular reduction or augmentation
- Lipofilling
- Lip reduction/enhancement (decreasing/enlarging lip size)
- Rhinoplasty (reshaping of the nose) including nose implants
- Trachea shave (Adam's apple shaving)/reduction thyroid chondroplasty (reduction of the thyroid cartilage)
Facial Reconstruction:

Other surgeries for assisting in body feminization or body masculinization are generally labeled cosmetic as they provide no significant improvement in physiologic function. However, these surgeries can be considered medically necessary depending on the unique clinical situation of a given patient’s condition. These surgeries include but are not limited to:

- Rhinoplasty: reshaping of the nose
- Rhytidectomy: face lift
- Blepharoplasty: removal of redundant skin of the upper and/or lower eyelids and protruding periorbital fat
- Hair removal via electrolysis, laser, and waxing/Hair transplantation
- Facial bone reduction: facial feminization
- Chin augmentation reshaping or enhancing the size of the chin
- Lip reduction/enhancement: decreasing/enlarging lip size
- Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage
- Genioplasty

Facial Reconstruction:

The procedures listed below are considered not medically necessary under standard benefit plan language. However, some benefit plans may expressly cover some or all of the procedures listed below for gender reassignment surgery.

Note: For New York regulated benefit plans (e.g., insured): The procedures listed below will be further reviewed on a case-by-case basis by a medical director with particular consideration given to whether the proposed procedure(s) advance an individual's ability to properly present and function in the identified gender role.

- Blepharoplasty
- Brow lift
- Cheek/malar implants
- Chin/nose implants, chin recontouring
- Collagen injections
- Face lift
- Forehead reduction and contouring
- Facial bone reduction (osteoplasty)
- Hair removal/hair transplantation
- Jaw reduction, contouring, augmentation
- Laryngoplasty
- Lip lift and lip filling
- Rhinoplasty
- Skin resurfacing (e.g., dermabrasion, chemical peels)
- Thyroid reduction chondroplasty
- Neck tightening
Facial Reconstruction:

The following surgery, services and procedures will be reviewed on a case by case basis. It is expected that the clinical rationale for each requested procedure is specifically documented in the letter of medical necessity from the treating physician:

1. Abdominoplasty, blepharoplasty, neck tightening or removal of redundant skin
2. Breast, brow, face or forehead lifts
3. Calf, cheek, chin, nose or pectoral implants
4. Collagen injections
5. Drugs to promote hair growth or loss
6. Facial bone reconstruction, reduction or sculpturing (including jaw shortening) and rhinoplasty
7. Hair transplantation
8. Lip reduction
9. Liposuction
10. Thyroid chondroplasty

Facial Reconstruction:

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

1. The individual is at least 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. 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
5. 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
6. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; and
7. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and
8. One letter, signed by the referring qualified mental health professional† who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

†See Discussion section for a list of procedures included in this group of procedures
Policy Title: Gender Reassignment/Gender Affirming Surgery and Treatments

Facial Reconstruction:

Based upon our assessment of the peer-reviewed literature, other surgeries and procedures for the treatment of gender dysphoria, including, but not limited to, facial feminization or masculinization surgery (i.e., blepharoplasty, liposuction of the face or neck, rhinoplasty, facial bone reconstruction, jaw shortening/sculpturing, chin augmentation, cheek augmentation, tracheal shaving/thyroid chondroplasty, hair reconstruction as part of forehead feminization surgery, and electrolysis or laser hair removal of face and/or neck hair (refer to Policy Guideline IX)), liposuction, lipofilling, and gluteal augmentation, will be reviewed on a case-by-case basis by a Health Plan medical director with experience in treating patients with mental health conditions and may be considered medically appropriate when ALL of the following criteria are met:

A. The patient has received a recommendation letter from a qualified mental health professional (refer to Policy Guidelines below).

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

1. The patient has a desire to live and be accepted as a member of their identified gender, usually accompanied by the wish to make their body as congruent as possible with the preferred gender through surgery and hormone treatment;
2. The gender dysphoria has been present persistently for at least one year;
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.

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.

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

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

F. The patient has completed a minimum of 24 months of hormone therapy, unless hormone therapy is medically contraindicated, or the patient has a history of a severe medical or psychiatric adverse effect from hormonal treatments.

G. The treating physician has determined that the requested procedure is medically necessary to treat the patient’s gender dysphoria.

Policy Issued By: Fallon Health

Policy Title: Gender Affirmation Services

Facial Reconstruction:
There are various other procedures commonly associated with Gender Affirmation Surgery. Fallon Health recognizes these procedures bring patients into a wide range of accepted appearances of their desired gender. While Fallon Health maintains a Cosmetic Surgery Clinical Coverage Criteria policy that applies to these procedures consideration will be given to how the procedure will affect gender identity.

**Policy Issued By:** [Geisinger Health Plan](#)

**Policy Title:** Gender Dysphoria and Gender Confirmation Treatment

**Facial Reconstruction:**

Facial implants, injections, or bone reduction (may be considered on a per-case basis with appropriate clinical documentation)

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

**Policy Title:** Transgender Health Services

**Facial Reconstruction:**

Harvard Pilgrim Health Care (HPHC) considers transgender surgical services as medically necessary when documentation and letters from the attending clinician(s) and mental health professional (MHP) responsible for managing the member's hormone therapies (if appropriate) and/or other related transgender care confirm ALL the following:

1. Member age 18 years or older has been diagnosed (by an appropriately trained MHP) with gender dysphoria/gender incongruence; AND
2. Member wishes to make his/her body as congruent as possible with the gender identity through surgery and/or hormone replacement (if appropriate); AND
3. Transgender surgery has been recommended by treating clinicians

Transfeminine surgeries covered include: Facial feminization procedures

- Tracheoplasty
- Blepharoplasty (lower and upper eyelid)
- Blepharoptosis
- Brow Ptosis
- Rhytidectomy
- Suction assisted lipectomy
- Genioplasty
- Osteoplasty
- Otoplasty
- Rhinoplasty
- Forehead contouring
- Mandible/jaw contouring

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**Policy Issued By:** [Harvard Pilgrim Health Care](#)

**Policy Title:** Transgender Health Services

**Facial Reconstruction:**
Harvard Pilgrim Health Care (HPHC) considers transgender surgical services as medically necessary when documentation and confirm ALL the following for transgender genital 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 TWO treating clinicians
3. Capacity to make fully informed decision and to consent for treatment
4. If significant medical or mental health concerns are present, they must be well controlled
5. Complete 12 continuous months of hormone therapy appropriate to the member’s the desired gender (unless medically contraindicated)

Transfeminine surgeries covered include:

- Tracheoplasty
- Blepharoplasty (lower and upper eyelid)
- Blepharoptosis
- Brow Ptosis
- Rhytidectomy
- Suction assisted lipectomy
- Genioplasty
- Osteoplasty
- Otoplasty
- Rhinoplasty
- Forehead contouring
- Mandible/jaw contouring

**Policy Issued By:** Health Net

**Policy Title:** Gender Affirming Procedures

**Facial Reconstruction:**

Medically Necessary/Reconstructive Surgery

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.

- Blepharoplasty
- Facial feminization
- Facial bone reduction
- Hair transplantation
- Hair removal
- Reduction thyroid chondroplasty
- Rhinoplasty

The above section clarifies how the plan administers benefits in accordance with the WPATH, SOC, Version 7. Provided a patient has been properly diagnosed with gender dysphoria or GID by a mental health professional or other provider type with appropriate training in behavioral health and competencies to conduct an assessment of gender dysphoria or GID, particularly when functioning as part of a multidisciplinary specialty team that provides access to
feminizing/masculinizing hormone therapy, certain options for social support and changes in
gender expression are considered to help alleviate gender dysphoria or GID.

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

Facial Reconstruction:

**Facial Reconstructive Surgical Consultation:**

a. The individual must have a diagnosis of persistent gender dysphoria.

b. The individual must be 18 years of age or older.

c. The individual must be able to provide informed consent;
   i. 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.
   ii. The treating surgeon must show that the individual has received appropriate education
       prior to the proposed procedure.

d. Evidence of 12 continuous months of hormone therapy, unless medical contraindication to
   hormone therapy documented.

e. Member has lived as the preferred gender for 12 continuous months.

f. A Medical Evaluation Form is to be completed (see Attachment B).

Alternatively, the Provider may submit the same content in the clinical documentation.

g. 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.
   i. The form/letter must evaluate facial feature(s) that cause persistent gender dysphoria,
      clarify goals and expectations, and assess self-acceptance, AND
   ii. Address how the presence of stated feature(s) impair function in relation to activities of
       daily living, AND
   iii. Address how reconstruction of said features will improve quality of life and daily function.

2. **Facial Reconstructive Surgery requests:**

a. All components of facial reconstructive consultation requests have been completed;

b. Clear documentation of proposed facial reconstructive procedures with evidence, to
   include photos, justifying medical necessity and reconstructive purpose of requested surgical
   procedure.

Policy Issued By: Kaiser Foundation Health Plan of Washington
Policy Title: Gender Reassignment Surgery

Facial Reconstruction:
Eligibility for MtF procedure: Laryngochrondroplasty is based on meeting ALL of the following criteria:

A. Member is at least 18 years old

B. Member has been diagnosed with persistent, well documented gender dysphoria.

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

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

E. Member has a current referral letter for laryngochrondroplasty surgery or other gender reassignment surgery from a qualified mental health professional who has independently assessed the patient. This assessment must be current within the past 12 months. For providers working within a multidisciplinary specialty team, the assessment and recommendation can be documented in the patient's chart. The referral is expected to cover the following recommended content:

F. Member has had a mental health evaluation and a medical evaluation and has been deemed to have no medical or psychological contraindications for surgery.

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Policy Issued By: Kaiser Permanente Northwest Region

Policy Title: Gender-Affirming Facial Procedures Medical Necessity Criteria

Facial Reconstruction:

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Gender-affirming facial procedures may be considered medically necessary when ALL of the following criteria are met:

1. With regard to the member:
   1. Member has persistent, well-documented gender dysphoria;
   2. Member is undergoing or has undergone other treatments to transition gender;
   3. Member has the capacity to make a fully informed decision and consent for treatment;
   4. Member is 18 years of age or older;
   5. Any significant medical or mental health concerns are well-controlled; AND

2. With regard to the requested procedure(s):
   1. Procedures for facial feminization may include (but are not limited to) mandible contouring, thyroid chondroplasty, rhinoplasty, and forehead reduction, among others. For each requested procedure, documentation that the member experiences dysphoria specifically associated with that facial element is required (e.g. documentation of dysphoria related to a stereotypically masculine nose for a requested rhinoplasty). Suitable documentation should be in the form of a mental health assessment produced by an experienced gender therapist who has evaluated the patient; AND
   2. The goal of each procedure is to alter or reshape the facial feature to an appearance that is within the range of normal for the member’s identified gender, as determined by a board-certified Plastic Surgeon.

Procedures intended solely to reduce the appearance of aging and will not result in significant improvement of the condition being treated are considered not medically necessary.
Policy Title: Transgender Surgery

Facial Reconstruction:

Male-to-Female (MtF): Tracheal Shave and facial hair removal as well as surgical area hair removal by electrolysis or laser are covered when referred by a Gender Pathways provider.

Policy Issued By: Mass General Brigham Health Plan

Policy Title: Gender Affirming Procedures

Facial Reconstruction:

Covered procedures when medical necessity criteria are met:

a. Forehead contouring (Osteoplasty)

b. Rhinoplasty/Septoplasty

c. Mandible/jaw contouring-reconstruction

d. Trachea shave or tracheoplasty

e. Blepharoplasty (only as needed in conjunction with other facial feminization procedures)

f. Brow lift g. Cheek augmentation

h. Rhytidectomy (Face lift) of forehead and cheek, excluding neck. Rhytidectomy is excluded for MassHealth members.

i. Genioplasty

j. Scalp (hairline) advancement

k. Lateral canthopexy

l. Lip lift

m. Lysis intranasal synchia

n. Suction-assisted lipectomy/liposuction (only as needed in conjunction with one of the above procedures).

Policy Issued By: Medi-Cal

Policy Title: Transgender Services

Facial Reconstruction:

Nationally recognized medical experts in the field of transgender health care have identified the following core services in treating gender dysphoria:

- Mental and behavioral health services
- Hormone therapy
- A variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender

Medically necessary covered services are those services that "are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury" (California Code of
Regulations [CCR, Title 22, Section 51303). Medical necessity is assessed and services shall be recommended by treating licensed mental health professionals and physicians and surgeons experienced in treating patients with gender dysphoria.

In the case of transgender services, "normal appearance" is determined by referencing the gender with which the recipient identifies. Reconstructive surgery to create a normal appearance for transgender recipients is determined to be medically necessary for the treatment of gender dysphoria on a case-by-case basis.

A service or the frequency of services available to a transgender recipient cannot be categorically limited. All medically necessary services must be provided timely. Limitations and exclusions, medical necessity determinations and/or appropriate utilization management criteria that are non-discriminatory may be applied.

Policy Issued By: Minnesota Health Care Programs
Policy Title: Gender-Confirming Surgery

Facial Reconstruction:

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

- Facial surgery may be considered for coverage on a case-by-case basis. Factors that may be considered in the case-by-case analysis include:
  1. How each requested procedure has a direct link to alleviating the documented symptoms of the gender dysphoria
  2. Documentation showing that no other physical or behavioral health condition could be causing the distress that the facial surgery attempts to address
  3. Explanation of how the symptoms will be alleviated through each requested procedure and how improvement will be measured and monitored.

Policy Issued By: Moda Health Plan
Policy Title: Gender Confirming Surgery

Facial Reconstruction:

Gender confirming facial procedures are considered medically appropriate when ALL the following are met:

1. Two referrals from licensed behavioral/mental health professionals (see Attachment A)
2. Persistent, well-documented gender dysphoria
3. Capacity to make a fully informed decision and to consent for treatment
4. Age of majority (18 years of age or older)
5. If significant medical or mental health concerns are present, they must be well controlled
6. 12 months of continuous hormone therapy as appropriate to the member's gender goals (unless hormones are not clinically indicated for the individual).
7. 12 continuous months of living in a gender role that is congruent with the member’s identity

The list of gender confirming procedures that would be considered are:

- Tracheal Shave
- Facial hair removal
- Rhinoplasty/Septoplasty
- Jaw Contouring
Policy Issued By: Oregon Health Authority (Oregon Health Plan)

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

Facial Reconstruction:

Individuals have received coverage for facial gender confirmation surgery under the Oregon Health Plan.

Policy Issued By: Tufts Health Plan

Policy Title: Transgender Surgical Procedures

Facial 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:

- Facial bone reduction
- Blepharoplasty
- Rhinoplasty
- Rhytidectomy
- Osteoplasty
- Genioplasty
- Forehead or cheek augmentation
- Mandible/jaw contouring
- Reduction thyroid chondroplasty

Policy Issued By: UniCare (Anthem)

Policy Title: Gender Affirming Surgery
**Facial Reconstruction:**

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

1. The individual is at least 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. 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
5. 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
6. Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender; and
7. The procedure directly addresses variation from normal appearance for the experienced gender (note: each procedure requested should be considered separately as some procedures may be cosmetic and others may be reconstructive); and
8. One letter, signed by the referring qualified mental health professional* who has independently assessed the individual, is required; the letter must have been signed within 12 months of the request submission.

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

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**Policy Issued By:** UnitedHealthcare

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

**Facial Reconstruction:**

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.

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**Policy Issued By:** UnitedHealthcare of California

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

**Facial 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:
   
   Thyroid chondroplasty (removal or reduction of the Adam’s Apple)

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

Facial 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)

Facial 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: University Health Alliance

Policy Title: Gender Identity Services

Facial 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.

1. Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction, feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization, are considered cosmetic.

2. Chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic.


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