National Medical Policy

Subject: **Gender Reassignment Surgery**

Policy Number: **NMP496**

Effective Date*: **November 2009**

Updated: **August 2015**

This National Medical Policy is subject to the terms in the IMPORTANT NOTICE at the end of this document

For Medicaid Plans: Please refer to the appropriate Medicaid Manuals for coverage guidelines prior to applying Health Net Medical Policies

The Centers for Medicare & Medicaid Services (CMS)
For Medicare Advantage members please refer to the following for coverage guidelines first:

Use	Source	Reference/Website Link
	National Coverage Determination (NCD)	
	National Coverage Manual Citation	
	Local Coverage Determination (LCD)*	
	Article (Local)*	
X	Other	CMS Manual System. Pub 100-03 Medicare National Coverage Determinations. Invalidation of National Coverage Determination 140.3 - Transsexual Surgery. June 27, 2014: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R169NCD.pdf
	None	Use Health Net Policy

Instructions

- Medicare NCDs and National Coverage Manuals apply to ALL Medicare members in ALL regions.
- Medicare LCDs and Articles apply to members in specific regions. To access your specific region, select the link provided under "Reference/Website" and follow the search instructions. Enter the topic and your specific state to find the coverage determinations for your region. *Note: Health Net must follow local coverage determinations (LCDs) of Medicare Administration Contractors (MACs) located outside their service area when those MACs have exclusive coverage of an item or service. (CMS Manual Chapter 4 Section 90.2)
- If more than one source is checked, you need to access all sources as, on occasion, an LCD or article contains additional coverage information than contained in the NCD or National Coverage Manual.

- If there is no NCD, National Coverage Manual or region specific LCD/Article, follow the Health Net Hierarchy of Medical Resources for guidance.

Note:

This policy is based on recommendations from the World Professional Association of Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association, Standards Of Care For Gender Identity Disorders, 7th version. See References for source.

Current Policy Statement

Gender reassignment surgery is considered medically necessary when a Health Net member has this benefit and has been diagnosed as having a gender identity disorder (GID), meets the criteria for the specific procedure(s), and:

- The individual is participating in a recognized gender identity treatment program
- The individual has 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 transsexual identity has been present persistently for at least two years, and
- The disorder is not a symptom of another mental disorder, and
- The individual should be knowledgeable regarding cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches, and
- The individual has obtained the appropriate letters of referral noted in Referral Letters section.

Referral Letters/Letters of Recommendation

Surgical treatments for gender dysphoria can be initiated with a referral(s) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

Breast/chest surgery:

One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

Genital surgery

Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

- The client's general identifying characteristics;
- Results of the client's psychosocial assessment, including any diagnoses;
- The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

- 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;
- A statement about the fact that informed consent has been obtained from the patient;
- A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.
- 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.

Criteria for Breast/Chest surgery (one letter of referral)

Female to Male:

Criteria for mastectomy and creation of a male chest:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. 18 years of age (age of majority in the US)
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note: Hormone therapy is not a pre-requisite.

Male to Female:

Criteria for breast augmentation (implants/lipofilling):

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. 18 years of age (age of majority in the US. If significant medical or mental health concerns are present, they must be reasonably well controlled.

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.

Genital Surgery (two letters of referral)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in female-to-male patients and for orchiectomy in male-to-female patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. 18 years of age (age of majority in the US);
4. If significant medical or mental health concerns are present, they must be well controlled.
5. Twelve (12) continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in female-to-male patients and for vaginoplasty in male-to-female patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. 18 years of age (age of majority in the US);
4. If significant medical or mental health concerns are present, they must be well controlled;
5. Twelve (12) continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. Twelve (12) continuous months of living in a gender role that is congruent with their gender identity (real-life experience);

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Examples of Female-to-Male genital procedures:

- Hysterectomy
- Mastectomy
- Metoidioplasty
- Phalloplasty
- Placement of testicular prostheses
- Salpingo-oophorectomy
- Scrotoplasty
- Urethroplasty
- Vaginectomy

Male-to-Female procedures:

- Clitoroplasty
- Labiaplasty
- Orchiectomy
- Penectomy
- Vaginoplasty
- Augmentation mammoplasty

Hormone Therapy (Based on WPATH version 7 recommendations)

The administration of exogenous endocrine agents to induce feminizing or masculinizing changes is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria. Hormone therapy is individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria.

Adolescents:

Adolescents may be eligible for puberty-suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, WPATH recommends that adolescents experience the onset of puberty to at least Tanner Stage 2 prior to the initiation of hormone therapy

Criteria for Puberty-Suppressing Hormones

In order for adolescents to receive puberty suppressing hormones, WPATH recommends that the following minimum criteria must be met:

1. The adolescent has demonstrated a long lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
2. Gender dysphoria emerged or worsened with the onset of puberty;
3. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process

Adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action.

Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

Adults
Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults. Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional.

The criteria for hormone therapy are as follows:
1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. If significant medical or mental health concerns are present, they must be reasonably well-controlled

Feminizing/masculinizing hormone therapy produces physical changes that are more congruent with a patient's gender identity. Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable.

<u>Masculinizing Hormone Therapy (Female to Male)</u>
The most commonly prescribed masculinizing hormone is intramuscular testosterone administered every 2–4 weeks. Other agents such as progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality

In female to male patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, and decreased percentage of body fat compared to muscle mass. In male to female patients physical changes such as breast growth (variable), decreased erectile function, decreased testicular size, and increased percentage of body fat compared to muscle mass are expected to occur.

Contraindications to masculinizing hormones therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or

higher. Consideration must be given to patients with a history of breast or other estrogen-dependent cancers, since the aromatization of testosterone to estrogen may increase risk in these patients.

Feminizing Hormone Therapy (Male to Female)
Commonly prescribed medications include oral estrogen (see contraindications below) and androgen-reducing medications (anti-androgens). A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen-reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity and, thus, diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone thereby reducing the risks associated with high-dose exogenous estrogen. Examples include:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.
- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin-releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. These medications are only available as injectables or implants.
- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5- alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.
- Cyproterone acetate (i.e. *Androcur®)* is a progestational compound with anti-androgenic properties. This medication is not commercially available in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere.
- Progestins (such as medroxyprogesterone such as Provera) use is controversial because of the potential adverse effects including depression, weight gain, and lipid changes and they are also suspected to increase breast cancer risk and cardiovascular risk in women. Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does

The risks of adverse events associated with feminizing/ masculinizing hormone therapy are dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, comorbidities, family history, and health habits). Feminizing hormones can cause increases in venous thromboembolic disease, gallstones, elevated liver enzymes, weight gain and hypertriglyceridemia and cardiovascular disease. Masculinizing hormones may increase the risk of polycythemia, weight gain, acne, androgenic alopecia (balding) and sleep apnea.

Contraindications to feminizing hormones such especially estrogen include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease.

Not Medically Necessary/Cosmetic

NOTE: Coverage of these procedures is subject to state mandates or by a specific schedule of benefits (SOB) or evidence of coverage (EOC) that

expressly states that coverage exists. Please refer to those documents for coverage guidance.

The following procedures, when used to specifically to improve the gender specific appearance of an individual undergoing or planning gender reassignment surgery, may be considered cosmetic and therefore not medically necessary, subject to coverage guidance noted above.

- Abdominoplasty (unless criteria in Health Net's Medical Policy for Abdominoplasty are met)
- Breast Augmentation (other than noted above)
- Blepharoplasty (unless criteria in Health Net's Medical Policy for Blepharoplasty are met)
- Electrolysis
- Face-lift
- Facial bone reduction
- Hair transplantation
- Hair removal
- Liposuction
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery

Definitions

Gender dysophoria (GD)	Gender dysphoria (formerly known as Gender identity disorder) refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)
SOC	Standards of Care
SRS	Sex reassignment surgery
FSFI	Female Sexual Function Index
SASB	Structural Analysis of Social Behavior
DMT	Defense Mechanism Test

Codes Related To This Policy

NOTE:
The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit documents and medical necessity criteria. This list of codes may not be all inclusive.

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. Health Net National Medical Policies will now include the preliminary ICD-10 codes in preparation for this transition. Please note that these may not be the final versions of the codes and that will not be accepted for billing or payment purposes until the October 1, 2015 implementation date.

ICD-9 Codes

302.50 –302.53	Transsexualism
302.6	Gender identify disorder in children
302.85	Gender identity disorder in adolescents or adults

ICD-10 Codes

F64-F64.9	Gender identity disorder
F64.1	Gender identity disorder in adolescence and adulthood
Z87.890	Personal history of sex reassignment

CPT Codes

55970	Intersex surgery, male to female
55980	Intersex surgery, female to male

HCPCS Codes

N/A

Scientific Rationale – Update August 2014

Per CMS Manual, Pub 100-03, Medicare National Coverage Determinations, Transmittal 169, a change request 8825 was issued. As a consequence of this decision, NCD 140.3 is no longer valid. Implementation of this policy shall be June 29, 2014. Because the NCD is no longer valid as of the effective date, its provisions are no longer a basis for denying claims for Medicare coverage of "transsexual surgery" under 42 CFR §405.1060. Moreover, any local coverage determinations used to adjudicate such claims may not be based on or rely on the provisions or reasoning from section 140.3 of Pub. 100-03, Medicare NCD Manual. In the absence of an NCD, contractors and adjudicators should consider whether any Medicare claims for these services are reasonable and necessary under §1862(a)(1)(A) of the SSA consistent with the existing guidance for making such decisions when there is no NCD.

Scientific Rationale – Initial

The term transsexual emerged into professional and public usage in the 1950s as a means of designating a person who aspired to or actually lived in the anatomically contrary gender role, whether or not hormones had been administered or surgery had been performed. In 1994, the DSM-IV committee replaced the diagnosis of transsexualism with Gender identity disorder (GID). Individuals with GID 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.

Harry Benjamin, a German endocrinologist, openly introduced the term "transsexualism", and treated with the assistance of colleagues of various disciplines, several hundred transsexuals. The World Professional Association of Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, (HBIGDA) was founded in 1979. The organization, devoted to the understanding and treatment of GIDs, consists of over 300 physicians, psychologists, social scientists, and legal professional members, all of whom are engaged in research and/or clinical practice that affects the lives of transgeneder and transsexual people. WPATH has established internationally accepted Standards of Care (SOC) for the treatment of gender identity disorders. These internationally accepted guidelines are designed to promote the health and welfare of persons with gender identity disorders. The Standards of Care are updated and revised as new scientific information becomes available.

As outlined in the Standards of Care (SOC), the therapeutic approach to GID consists of three elements or phases, sometimes labeled triadic therapy: a real-life experience in the desired role, hormones of the desired gender and surgery to change the genitalia and other sex characteristics.

Not all persons with GIDs need or want all three elements of triadic therapy. Many adults with GID find comfortable, effective ways of living that do not involve all the components of the triadic treatment sequence. While some individuals manage to do this on their own, psychotherapy can be very helpful in bringing about the discovery and maturational processes that enable self-comfort. However, not every adult gender patient requires psychotherapy in order to proceed with hormone therapy, the real-life experience, hormones, or surgery.

Hormonal treatment, when medically tolerated, should precede any genital surgical interventions. Hormone therapy includes androgens administered to biologic females and estrogens, progesterone, and testosterone-blocking agents administered to biologic males. Satisfaction with the hormone's effects consolidates the person's identity as a member of the preferred sex and gender and further adds to the conviction to proceed. Dissatisfaction with hormonal effects may signal ambivalence about proceeding to surgical interventions. The treatment of biologic males with estrogens results in breast growth, some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size, and less frequent, less firm erections. Most changes are reversible, although breast enlargement will not completely reverse after discontinuation of treatment. Treatment of biologic females with testosterone results in a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness. Reversible changes include increased upper body strength, weight gain, increased social and sexual interest and arousability, and decreased hip fat.

Cross-sex hormone administration may be associated with a variety of complications. In male-to-female transsexuals, side effects/complications of hormone therapy may include venous thromboembolism, development of benign pituitary prolactinomas, infertility, weight gain, emotional lability, liver disease, gallstone formation, somnolence, hypertension, and diabetes mellitus. For female-to-male transsexuals, side effects/complications of hormone therapy may include infertility, acne, emotional lability, increases in sexual desire, shift of lipid profiles to male patterns thus increasing risk of cardiovascular disease, and the potential to develop benign and malignant liver tumors and hepatic dysfunction.

The act of fully adopting a new or evolving gender role or gender presentation in everyday life is known as the real-life experience. The real-life experience is essential to the transition to the gender role that is congruent with the patient’s gender identity. The real-life experience tests the individual’s resolve, capacity to function in the preferred gender, and adequacy of social, economic, and psychological supports.

Sex reassignment surgery (SRS), involves genital reconstruction surgery and other procedures, all of which require skilled surgery and postoperative care. SRS may be a part of the treatment approach for individuals with GID. During SRS for a male-to-female, a neovagina is surgically constructed, usually using the penile skin for vaginal lining and scrotal skin for the labia. SRS for a female-to-male transsexual includes surgical removal of the breasts, uterus and ovaries. Most commonly, a metadoioplasty may be performed. With this technique the urethra is lengthened using an anterior vaginal wall flap to reach the tip of the phallic glans, and the clitoris is partially released and stretched by resection of the ventral chordae. From the labia

majora a scrotum can be constructed in which testicular prostheses can be implanted. This surgical intervention allows the patient to urinate standing. Free flaps removed from arms or legs can be used to construct a neophallus.

Wyers et al (2009) assessed the physical, mental, and sexual health among fifty transsexual women who had undergone SRS $\geq$ 6 months previously. Self-reported physical and mental health using the Dutch version of the Short-Form-36 (SF-36) Health Survey; sexual functioning using the Dutch version of the Female Sexual Function Index (FSFI). Satisfaction with gender-related bodily features as well as with perceived female appearance; importance of sex, relationship quality, necessity and advisability of gynecological exams, as well as health concerns and feelings of regret concerning transition were scored. Compared with reference populations, transsexual women scored good on physical and mental level (SF-36). Gender-related bodily features were shown to be of high value. Appreciation of their appearance as perceived by others, as well as their own satisfaction with their self-image as women obtained a good score (8 and 9, respectively). However, sexual functioning as assessed through FSFI was suboptimal when compared with biological women, especially the sublevels concerning arousal, lubrication, and pain. Superior scores concerning sexual function were obtained in those transsexual women who were in a relationship and in heterosexuals.

De Cuypere et al (2005) followed 55 transsexual patients (32 male-to-female and 23 female-to-male) after SRS evaluating sexual and general health outcome. Relatively few and minor morbidities were observed in the group, most of which were mostly reversible with appropriate treatment. The author noted a trend toward more general health problems in male-to-females was seen, noting that this may be possibly explained by older age and smoking habits. Although all male-to-females, treated with estrogens continuously had total testosterone levels within the normal female range because of estrogen effects on sex hormone binding globulin, only 32.1% reached normal free testosterone levels. After SRS, the transsexual person's expectations were met at an emotional and social level, but less so at the physical and sexual level even though a large number of transsexuals (80%) reported improvement of their sexuality. The female-to-males masturbated significantly more frequently than the male-to-females, and a trend to more sexual satisfaction, more sexual excitement, and more easily reaching orgasm was seen in the female-to-male group. The majority of participants reported a change in orgasmic feeling, toward more powerful and shorter for female-to-males and more intense, smoother, and longer in male-to-females. Over two-thirds of male-to-females reported the secretion of a vaginal fluid during sexual excitation, originating from the Cowper's glands, left in place during surgery. In female-to-males with erection prosthesis, sexual expectations were more realized (compared to those without), but pain during intercourse was more often reported.

Lawrence (2003) examined factors associated with satisfaction or regret following SRS in 232 male-to-female transsexuals operated on by one surgeon using a consistent technique. Participants, all of whom were at least 1-year postoperative, completed a written questionnaire concerning their experiences and attitudes. Participants reported overwhelmingly that they were happy with their SRS results and that SRS had greatly improved the quality of their lives. None reported outright regret and only a few expressed even occasional regret. Dissatisfaction was most strongly associated with unsatisfactory physical and functional results of surgery. Most indicators of transsexual typology, such as age at surgery, previous marriage or parenthood, and sexual orientation, were not significantly associated with subjective outcomes. Compliance with minimum eligibility requirements for SRS specified by the Harry Benjamin International Gender Dysphoria Association was not associated with more favorable subjective outcomes.

Bodlund and Kullgren (1996) followed up on nineteen transsexuals, approved for sex reassignement after 5 years. Outcome was evaluated as changes in seven areas of social, psychological, and psychiatric functioning. At baseline the patients were evaluated according to axis I, II, V (DSM-III-R), SCID screen, SASB (Structural Analysis of Social Behavior), and DMT (Defense Mechanism Test). At follow-up all but 1 were treated with contrary sex hormones, 12 had completed sex reassignment surgery, and 3 females were waiting for phalloplasty. One male transsexual regretted the decision to change sex and had quit the process. Two transsexuals had still not had any surgery due to older age or ambivalence. Overall, 68% (n = 13) had improved in at least two areas of functioning. In 3 cases (16%) outcome were judged as unsatisfactory and one of those regarded sex change as a failure. Another 3 patients were mainly unchanged after 5 years. Female transsexuals had a slightly better outcome, especially concerning establishing and maintaining partnerships and improvement in socio-economic status compared to male transsexuals. Baseline factors associated with negative outcome (unchanged or worsened) were presence of a personality disorder and high number of fulfilled axis II criteria. SCID screen assessments had high prognostic power. Negative self-image, according to SASB, predicted a negative outcome, whereas DMT variables were not correlated to outcome.

According to a NCD on Transsexual Surgery from the Centers for Medicare & Medicaid Services:

> "Transsexual surgery for sex reassignment of transsexuals is controversial. Because of the lack of well controlled, long term studies of the safety and effectiveness of the surgical procedures and attendant therapies for transsexualism, the treatment is considered experimental. Moreover, there is a high rate of serious complications for these surgical procedures. For these reasons, transsexual surgery is not covered."

Review History

November 2009	Medical Advisory Council, initial approval
February 2011	Added Medicare table, no other changes
February 2012	Update – no revisions
February 2013	Updated coding, no revisions
June 2013	Revised format, removed "chromosomal abnormalities" from policy statement, revised hormone therapy requirements, clarified Letters of Recommendation
February 2014	Added section on Hormone Therapy
August 2014	Removed website on Medicare NCD on Transsexual Surgery. Per Medicare notice, NCD 140.3 was removed June 27, 2014. Additionally, references to transsexual surgery have been removed from Pub. 100-02, Medicare Benefit Policy Manual. Because the NCD is no longer valid as of the effective date, its provisions are no longer a basis for denying claims for Medicare coverage of "transsexual surgery" under 42 CFR §405.1060.
November 2014	Under Not Medically Necessary, added instructions to review member coverage documents and state mandates for coverage guidance
August 2015	Update - No revisions as of date of this update as it is based on the most current WPATH Version 7

This policy is based on the following evidence-based guidelines:

1. Meyer G, Bockting W, Cohen-Kettenis P, et al. The Harry Benjamin International Gender Dysphoria Association's Standards Of Care For Gender Identity Disorders, Sixth Version. Feb 2001.
2. Hayes Medical Technology Directory. Sex Reassignment Surgery and Associated Therapies for the Treatment of Gender Identity Disorders. December 1, 2004. Updated January 6, 2009.
3. The World Professional Association for Transgender Health. Standards Of Care for the Health of the Transsexual, Transgender, and Gender Nonconforming People. 7th Version.

References – Update August 2014

1. CMS Manual System. Pub 100-03 Medicare National Coverage Determinations. Invalidation of National Coverage Determination 140.3 - Transsexual Surgery. June 27, 2014: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R169NCD.pdf

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1. The World Professional Association for Transgender Health. Standards Of Care for the Health of the Transsexual, Transgender, and Gender Nonconforming People. 7th Version.

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1. Goldman: Goldman's Cecil Medicine, 24th ed. Management of Individuals with Disorders of Sexual Development: Gender Role and Identity. 2011 Saunders, An Imprint of Elsevier
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2. Gorin-Lazard A, Baumstarck K, Boyer L, et al. Is Hormonal Therapy Associated with Better Quality of Life in Transsexuals? A Cross-Sectional Study. J Sex Med. 2011 Dec 6. doi: 10.1111/j.1743-6109.2011.02564.x.
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4. Wierckx K, Elaut E, Van Caenegem E, et al. Sexual desire in female-to-male transsexual persons: exploration of the role of testosterone administration. Eur J Endocrinol. 2011 Aug;165(2):331-7.
5. Wierckx K, Van Caenegem E, Elaut E, et al. Quality of life and sexual health after sex reassignment surgery in transsexual men. J Sex Med. 2011 Dec;8(12):3379-88. doi: 10.1111/j.1743-6109.2011.02348.x.

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2. De Cuypere G, T'Sjoen G, Beerten R, et al. Sexual and physical health after sex reassignment surgery. Arch Sex Behav. 2005 Dec;34(6):679-90.
3. Jarolím L, Sedý J, Schmidt M, et al. Gender reassignment surgery in male-to-female transsexualism: A retrospective 3-month follow-up study with anatomical remarks. J Sex Med. 2009 Jun;6(6):1635-44
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Health Net reserves the right to amend the Policies without notice to providers or Members. In some states, prior notice or website posting is required before an amendment is deemed effective.

No Medical Advice.
The Policies do not constitute medical advice. Health Net does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

No Authorization or Guarantee of Coverage.
The Policies do not constitute authorization or guarantee of coverage of particular procedure, drug, service or supply. Members and providers should refer to the Member contract to determine if exclusions, limitations, and dollar caps apply to a particular procedure, drug, service or supply.

Policy Limitation: Member's Contract Controls Coverage Determinations.
Statutory Notice to Members: The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. The determination of coverage for a particular procedure, drug, service or supply is not based upon the Policies, but rather is subject to the facts of the individual clinical case, terms and conditions of the member's contract, and requirements of applicable laws and regulations. The contract language contains specific terms and conditions, including pre-existing conditions, limitations, exclusions, benefit maximums, eligibility, and other relevant terms and conditions of coverage. In the event the Member's contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Member's contract shall govern. The Policies do not replace or amend the Member's contract.

Policy Limitation: Legal and Regulatory Mandates and Requirements
The determinations of coverage for a particular procedure, drug, service or supply is subject to applicable legal and regulatory mandates and requirements. If there is a discrepancy between the Policies and legal mandates and regulatory requirements, the requirements of law and regulation shall govern.

Reconstructive Surgery
CA Health and Safety Code 1367.63 requires health care service plans to cover reconstructive surgery. "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function or

(2) To create a normal appearance, to the extent possible.

Reconstructive surgery does not mean "cosmetic surgery," which is surgery performed to alter or reshape normal structures of the body in order to improve appearance.

Requests for reconstructive surgery may be denied, if the proposed procedure offers only a minimal improvement in the appearance of the enrollee, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery.

Reconstructive Surgery after Mastectomy
California Health and Safety Code 1367.6 requires treatment for breast cancer to cover prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the co-payment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits. "Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Policy Limitations: Medicare and Medicaid
Policies specifically developed to assist Health Net in administering Medicare or Medicaid plan benefits and determining coverage for a particular procedure, drug, service or supply for Medicare or Medicaid members shall not be construed to apply to any other Health Net plans and members. The Policies shall not be interpreted to limit the benefits afforded Medicare and Medicaid members by law and regulation.