



National Medical Policy

Subject: Gender Reassignment Surgery

Policy Number: NMP496

Effective Date*: November 2009

Updated: February 2011

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

The Centers for Medicare & Medicaid Services (CMS)

For Medicare Advantage members please refer to the following for coverage guidelines first:

Use	Source	Reference/Website
	National Coverage Decision (NCD)	
	CMS Benefit Manual	
	Local Coverage Decision (LCD)	
	Article (Local)	
	Other	
X	None	Use Health Net Policy

Instructions

- Medicare NCDs and Benefit 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, then enter the topic and your specific state to find the coverage instructions for your region
- 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 Benefit Manual
- If there is no NCD, Benefit Manual or LCD specific to your region, please use Health Net National Medical Policy

Gender reassignment surgery is specifically excluded under many benefit plans.

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, available at: <http://wpath.org/Documents2/socv6.pdf>

Current Policy Statement (Update February 2011 – A Medline search failed to reveal any studies that would cause Health Net, Inc. to change its current position)

When a Health Net member has the benefit for gender reassignment surgery, all of the following criteria must be met:

1. The individual is 18 years of age or older;
2. The individual is diagnosed as having a gender identity disorder (GID), and meets all of the following criteria:
 - 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;
 - The transsexual identity has been present persistently for at least two years;
 - The disorder is not a symptom of another mental disorder or a chromosomal abnormality.
3. The individual is participating in a recognized gender identity treatment program and all of the following criteria has been met:
 - The individual has successfully lived full time in the preferred gender for twelve months prior to genital surgery, without periods of returning to the original gender (real-life experience); and
 - Prior to institution of hormone therapy or breast surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty), one letter of recommendation from a mental health professional has been submitted to the physician who will be responsible for the patient's medical treatment; and
 - Unless medically contraindicated, the individual has undergone 12 months of continuous hormonal therapy; and
 - Prior to initiating genital surgery, two letters of recommendation from mental health professionals have been submitted, one of which is an extensive report*
 - The individual should be knowledgeable regarding cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches

*Note: If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a Ph.D. clinical psychologist. If the first letter is from the patient's psychotherapist, the second letter should be from a person who has only played an evaluative role for the patient.

Genital surgery as part of initial gender reassignment surgery may include any of the following:

Male-to-Female procedures:

- Clitoroplasty
- Labiaplasty
- Orchiectomy
- Penectomy
- Vaginoplasty

- Augmentation mammoplasty when 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 gender role.

Female-to-Male procedures:

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

The following procedures, when used to improve the gender specific appearance of an individual undergoing or planning gender reassignment surgery, are considered cosmetic and therefore considered not medically necessary:

- Abdominoplasty
- Breast Augmentation (other than noted above)
- Blepharoplasty
- Electrolysis
- Face-lift
- Facial bone reduction
- Hair transplantation
- Laser hair removal
- Liposuction
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery

Definitions

GID	Gender identity disorder
SOC	Standards of Care
SRS	Sex reassignment surgery
SF - 36	Short-Form-36
FSFI	Female Sexual Function Index
SASB	Structural Analysis of Social Behavior
DMT	Defense Mechanism Test

Codes Related To This Policy

ICD-9 Codes

302.50 –305.53	Trans-sexulism
302.85	Gender identity disorders in adolescents or adults

CPT Codes

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

HCPCS Codes

N/A

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, (HBI-GDA) 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 transgender 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 reassignment 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

Patient Education Websites

English

1. MedlinePlus. Gender Identity Disorder. Available at:
<http://www.nlm.nih.gov/medlineplus/ency/article/001527.htm>

Spanish

1. MedlinePlus. Trastorno de identidad de género. Available at:
<http://www.nlm.nih.gov/medlineplus/spanish/ency/article/001527.htm>

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. Available at:
<http://wpath.org/Documents2/socv6.pdf>
2. Hayes Medical Technology Directory. Sex Reassignment Surgery and Associated Therapies for the Treatment of Gender Identity Disorder

References Initial

1. Bodlund O, Kullgren G. Transsexualism--general outcome and prognostic factors: a five-year follow-up study of nineteen transsexuals in the process of changing sex. Arch Sex Behav. 1996 Jun;25(3):303-16.
2. Centers for Medicare & Medicaid Services. NCD for Transsexual Surgery. Available at:
http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=140.3&ncd_version=1&basket=ncd%3A140%2E3%3A1%3ATranssexual+Surgery
3. 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.

4. 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
5. Kraemer B, Delsignore A, Schnyder U, Hepp U. Body image and transsexualism. *Psychopathology.* 2008;41(2):96-100.
6. Krege S, Bex A, Lümmer G, Rübber H. Male-to-female transsexualism: a technique, results and long-term follow-up in 66 patients. *BJU Int.* 2001 Sep;88(4):396-402
7. Kuhn A, Bodmer C, Stadlmayr W, et al. Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertil Steril.* 2008 Nov 4
8. Lawrence AA. Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Arch Sex Behav.* 2003 Aug;32(4):299-315.
9. Lobato MI, Koff WJ, Manenti C, et al. Follow-up of sex reassignment surgery in transsexuals: a Brazilian cohort. *Arch Sex Behav.* 2006 Dec;35(6):711-5.
10. Rauchfleisch U, Barth D, Bategay R. Results of long-term follow-up of transsexual patients. *Nervenarzt.* 1998 Sep;69(9):799-805
11. Sørensen T. 12: A follow-up study of operated transsexual males. *Acta Psychiatr Scand.* 1981 May;63(5):486-503.
12. Tsoi WF. Follow-up study of transsexuals after sex-reassignment surgery. *Singapore Med J.* 1993 Dec;34(6):515-7.
13. Weyers S, Elaut E, De Sutter P, et al. Long-term assessment of the physical, mental, and sexual health among transsexual women. *J Sex Med.* 2009 Mar;6(3):752-60.

Important Notice

General Purpose

Health Net's National Medical Policies (the "Policies") are developed to assist Health Net in administering plan benefits and determining whether a particular procedure, drug, service or supply is medically necessary. The Policies are based upon a review of the available clinical information including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the drug or device, evidence-based guidelines of governmental bodies, and evidence-based guidelines and positions of select national health professional organizations. Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract, including medical necessity requirements. Health Net may use the Policies to determine whether under the facts and circumstances of a particular case, the proposed procedure, drug, service or supply is medically necessary. The conclusion that a procedure, drug, service or supply is medically necessary does not constitute coverage. The member's contract defines which procedure, drug, service or supply is covered, excluded, limited, or subject to dollar caps. The policy provides for clearly written, reasonable and current criteria that have been approved by Health Net's National Medical Advisory Council (MAC). The clinical criteria and medical policies provide guidelines for determining the medical necessity criteria for specific procedures, equipment, and services. In order to be eligible, all services must be medically necessary and otherwise defined in the member's benefits contract as described in this "Important Notice" disclaimer. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to practice medicine.

Policy Effective Date and Defined Terms.

The date of posting is not the effective date of the Policy. The Policy is effective as of the date determined by Health Net. All policies are subject to applicable legal and regulatory mandates and requirements for prior notification. If there is a discrepancy between the policy effective date and legal mandates and regulatory requirements, the requirements of law and regulation shall govern. * In some states, new or revised policies require prior notice or posting on the website before a policy is deemed effective. For information regarding the effective dates of Policies, contact your provider representative. The Policies do not include definitions. All terms are defined by Health Net. For information regarding the definitions of terms used in the Policies, contact your provider representative.

Policy Amendment without Notice.

Health Net reserves the right to amend the Policies without notice to providers or Members. In some

states, new or revised policies require prior notice or website posting 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.

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. Coverage decisions are the result of the terms and conditions of the Member's benefit contract. The Policies do not replace or amend the Member's contract. If there is a discrepancy between the Policies and the Member's contract, the Member's contract shall govern.

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.