MN. 010.I Gender Affirming Surgery

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Thank you for being a valued provider for members in one or more of our health plans: Jefferson Health Plans Medicare Advantage, Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans CHIP, and/or Jefferson Health Plans EverWell (our Medicaid plan).

PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans lines of business unless noted below.

Effective October 13, 2026, services for the treatment of gender dysphoria, including puberty-blocking medications and gender transition-related surgical procedures, are no longer covered under the Children's Health Insurance Program (CHIP) line of business.

POLICY STATEMENT

COVERED

The surgical treatment of gender affirmation is considered medically necessary when **ALL** of the following criteria are met:

1. Referral from a qualified mental health professional and, in accordance with the recommendations from the World Professional Association for Transgender Health (WPATH), the referral letter must include:

   (a) Assessment of gender identity and transgender / gender diverse (TGD).
   (b) Availability of support from family, friends, and peers (e.g., in-person or online contact with other transsexual, transgender or gender nonconforming individuals or groups).
   (c) Diagnosis of transgender / gender diverse (TGD) based on DSM-5 requirements.
   (d) History and development of transgender / gender diverse (TGD) feelings.

(e) Impact of stigma attached to gender nonconformity on mental health.

(f) Psychological readiness for the requested surgeries.

2. Member demonstrates a capacity to make a fully informed decision to consent to treatment.

3. Member has been living in the gender role that is congruent with the member's gender identity for a significant period of time.

Certain surgeries are only considered medically necessary as set forth below

1. Mastectomy. Mastectomy may be considered medically necessary for female-to-male members when ALL the following criteria are met:

(a) Assessment performed by a qualified mental health professional results in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

(b) Member demonstrates a capacity to make a fully informed decision to consent to treatment.

(c) Members are 18 or older.

(Consideration will be given to members under the age 18 when: member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals (unless hormone therapy is medically contraindicated) and member has completed 12 continuous months of full-time living in a gender role that is congruent with the member's gender identity. In addition, legal guardian consent, as well as letters from two qualified mental health practitioners who have independently evaluated the member, will be required)

(d) Significant medical or mental health concerns are optimally managed and well controlled (if present).

(e) A referral for mastectomy from a qualified mental health professional has been provided.

2. Augmentation Mammaplasty. Augmentation Mammaplasty with implantation of breast prostheses may be considered medically necessary for male-to-female members when ALL the following criteria are met:

(a) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

(b) Member demonstrates a capacity to make fully informed decisions to consent to treatment.

(c) Members are 18 or older.

(Consideration will be given to members under the age 18 when: member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals (unless hormone therapy is medically contraindicated) and member has completed 12 continuous months of full-time living in a gender role that is congruent with the member's gender identity. In addition, legal guardian consent, as well as letters from two qualified mental health practitioners who have independently evaluated the member, will be required).

(d) Significant medical or mental health concerns are optimally managed and well controlled (if present)

(e) A referral for augmentation mammoplasty from a qualified mental health professional has been provided.

3. Hysterectomy, Salpingectomy and/or Oophorectomy. Hysterectomy, salpingectomy and/or oophorectomy may be considered medically necessary for female-to-male members and orchiectomy may be considered medically necessary for male-to-female members when **ALL of** the following criteria are met:

(a) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

(b) Member demonstrates a capacity to make a fully informed decision and can consent to treatment.

(c) Members are 18 or older.

(d) Significant medical or mental health concerns are optimally managed and well controlled (if present)

(e) Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role)

(f) Referrals for hysterectomy, salpingectomy and/or oophorectomy or orchiectomy have been provided by two qualified mental health professionals who have independently assessed the member (one of these two referrals may be from the qualified mental health professional performing the initial assessment)

4. Genital Reconstructive Surgery. Genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty with implantation of penile prosthesis and scrotoplasty with insertion of testicular implants for female-to-male members; penectomy, vaginoplasty, vulvoplasty, labiaplasty, and clitoroplasty for male-to-female members) may be considered medically necessary when **ALL of** the following criteria are met:

(a) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

(b) Member demonstrates a capacity to make a fully informed decision to consent to treatment.

(c) Members are 18 or older.

(d) Significant medical or mental health concerns are optimally managed and well controlled (if present)

(e) Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role).

(f) Referrals for genital reconstructive surgery have been provided by two qualified mental health professionals who have independently assessed the member (one of these two referrals may be from the qualified mental health professional performing the initial assessment).

Gender specific services for the transgender community

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

(a) Breast cancer screening may be medically necessary for transmasculine persons who have not undergone chest masculinization surgery.

(b) Prostate cancer screening may be medically necessary for transfeminine people who have retained their prostate.

Procedures usually considered cosmetic (see list below) may be covered for gender affirmation when all the following criteria are met:

(a) Member is age 18 or older.

(b) Assessment performed by a qualified mental health professional result in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

(c) Member demonstrates a capacity to make a fully informed decision and can consent to treatment.

(d) Significant medical or mental health concerns are optimally managed and well controlled (if present).

(e) Referral from one qualified mental health professionals who have independently assessed the member.

(f) Member has completed 12 continuous months of physician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated (hormone therapy may be concurrent with living in gender role).

(g) One pre-surgical evaluation by the surgeon (within 6 months of the procedure request) with the following documentation: the nature of the planned surgical procedure(s); if surgery is staged expected timetable; diagram of the specific area requiring pre-operative hair removal, if applicable etc.

List of covered procedures:

- Facial and neck reconstructive procedures (facial masculinization/ facial feminization)
- Blepharoplasty
- Cervicoplasty/ platysmaplasty
- Chin augmentation (genioplasty, mentoplasty)
- Face bone reduction
- Facial prosthesis (e.g., nasal, orbital)
- Forehead reduction
- Lip reduction/ enhancement
- Orthognathic procedures
- Rhinoplasty
- Septoplasty
- Rhytidectomy (following alteration of the underlying skeletal structures because of gender affirming facial reconstruction)
- Trachea shave/ reduction
- Thyroid chondroplasty
- Hair removal/ electrolysis when required for gender reconstructive surgery (e.g. electrolysis of free flap or other donor skin sites for breast and genital reconstructive surgery)
- Voice therapy
- Voice modification surgery (i.e., laryngoplasty, cricothyroid approximation) if needed after 12 months of hormonal therapy and voice therapy

Procedures usually considered cosmetic and not covered for gender affirmation

List of non-covered procedures:

- Body contouring procedures (e.g., abdominoplasty, suction-assisted lipectomy and lipofilling)
- Botox injections
- Calf implantation
- Chemical peels
- Collagen injections and dermal fillers (e.g., Sculptra, Radiesse)
- Dermabrasion
- Excision of redundant skin
- Gluteal augmentation (e.g., silicone implants, fat transfer, fat grafting)
- Hair reconstruction (e.g., hair removal/electrolysis, hair transplantation, wigs) except during skin preparation for gender reconstructive surgical procedures
- Mastopexy
- Monsplasty
- Nontherapeutic tattooing
- Otoplasty
- Pectoral implantation
- Skin resurfacing

Other Non-Covered Services:

1. Gender affirming surgery for members who are dissatisfied with their natal sex or prefer to be the opposite sex, without clinically significant distress or impairment resulting in a diagnosis of transgender / gender diverse (TGD) meeting DSM-5 criteria.

2. Reversal of gender affirming surgery.

3. More than one breast augmentation is considered not medically necessary. This does not include the medically necessary replacement of breast implants.

4. Procedures for the preservation of fertility , including, but not limited to, the procurement, preservation, and storage of sperm, oocytes, or embryos.

POLICY GUIDELINES

In all cases, the appropriate documentation supporting medical necessity must be kept on file and, upon request, presented to us.

The definition of medical necessity may vary by product due to state and federal regulatory requirements.

The determination of medical necessity for gender affirming surgery is based on clinical data including, but not limited to, indicators that would affect the relative risks and benefits of the procedure (e.g., post-operative recovery).

CODING

*Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive. **CPT® is a registered trademark of the American Medical Association*

See Coding table:

CPT Code	Description
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete.
19318	Breast reduction
19325	Mammaplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction

CPT Code	Description
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin.
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21138	Reduction forehead: contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
31592	Cricotracheal resection
31750	Tracheoplasty; cervical
31899	Unlisted procedure, trachea, bronchi

CPT Code	Description
40150	Excision of lip; transverse wedge excision with primary closure
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55150	Resection of scrotum
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55899	Unlisted procedure, male genital system
55970	Intersex surgery, male to female
55980	Intersex surgery, female to male
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical
57106	Vaginectomy, partial removal of vaginal wall
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)

CPT Code	Description
57110	Vaginectomy; complete removal of vaginal wall
57111	Vaginectomy; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction of artificial vagina, with graft
57292	Construction of artificial vagina, without graft
57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft, open approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 gms or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g

CPT Code	Description
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g.
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy).
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral.
58999	Unlisted procedure, female genital system (nonobstetrical)
89258	Cryopreservation; embryo(s)
89335	Cryopreservation, reproductive tissue, testicular
89337	Cryopreservation, mature oocyte(s)
89342	Storage (per year); embryo(s)
89344	Storage (per year); reproductive tissue, testicular/ovarian
89346	Storage (per year); oocyte(s)
89352	Thawing of cryopreserved; embryo(s)
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
89398	Unlisted reproductive medicine laboratory procedure
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

HCPCS Code	Description
S4030	Sperm procurement and cryopreservation services; initial visit
S4040	Monitoring and storage of cryopreserved embryos, per 30 days

ICD-10 Codes	Description
F64	Gender identity disorders
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit contract on the date the service was rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

DESCRIPTION OF SERVICES

Gender Identity Disorder (GID), more commonly known as transsexualism, is a condition recognized in the Diagnostic and Statistical Manual of Mental Disorders,

(DSM-V,), published by the American Psychiatric Association. Transsexualism is also recognized in the ICD Classification of Mental and Behavioral Disorders, tenth revision, as endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as of 1994.

The criteria listed for Gender Identity Disorders (GID) including transsexualism are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity, which is developed in early childhood and understood to be firmly established by age 4, though for some transgender individuals, gender identity may remain somewhat fluid for many years. The ICD 10 descriptive criteria were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment known as transgender / gender diverse (TGD) that is often associated with transsexualism.

The World Professional Association for Transgender Health (WPATH) is an international association devoted to the understanding and treatment of individuals with gender identity disorders.

The WPATH Standards of Care for Gender Identity Disorders (Standards of Care), first issued in 1979, articulates the "professional consensus about the psychiatric, psychological, medical and surgical management of GID." Periodically revised to reflect the latest clinical practice and scientific research, the Standards also unequivocally reflect this Association's conclusion that treatment is medically necessary.

The current Board of Directors of the WPATH herewith expresses its conviction that gender affirmation, properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/ortransgender / gender diverse (TGD). Gender affirmation plays an undisputed role in contributing toward favorable outcomes, and comprises Real Life Experience, legal name and sex change on identity documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures. Genital reconstruction is not required for social gender recognition, and such surgery should not be a prerequisite for document or record changes; the Real-Life Experience component of the transition process is crucial to psychological adjustment, and is usually completed prior to any genital reconstruction, when appropriate for the patient, according to WPATH Standards of Care. Changes to documentation are important aids to social functioning and are a necessary component of the pre-surgical process; delay of document changes may have a deleterious impact on a patient's social integration and personal safety.

Medically necessary gender affirming procedures also include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient (including breast prostheses if necessary), genital reconstruction (by various techniques which must be appropriate to each patient,

including, for example, skin flap hair removal, penile and testicular prostheses, as necessary), facial hair removal, and certain facial plastic reconstruction (as appropriate to the patient).

Furthermore, not every patient will have a medical need for identical procedures; clinically appropriate treatments must be determined on an individualized basis with the patient's physician.

The medical procedures attendant to gender affirmation are not "cosmetic" or "elective" or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense but are understood to be medically necessary for the treatment of the diagnosed condition. Further, the WPATH Standards of Care consider it unethical to deny eligibility for gender affirming surgeries or hormonal therapies solely on the basis of blood seropositivity for infections such as HIV or hepatitis.

These medical procedures and treatment protocols are not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient. For example, a recent study of female-to-male transsexuals found significantly improved quality of life following cross-gender hormonal therapy. Moreover, those who had also undergone chest reconstruction had significantly higher scores for general health, social functioning, as well as mental health.

The WPATH Board of Directors urges state healthcare providers and insurers throughout the world to eliminate transgender or trans-sex exclusions and to provide coverage for transgender patients including the medically prescribed gender affirming services necessary for their treatment and well-being, and to ensure that their ongoing healthcare (both routine and specialized) is readily accessible.

CLINICAL EVIDENCE

N/A

DEFINITIONS

GENDER AFFIRMING SURGERY

Gender affirming surgery is the surgical procedure (or procedures) by which a transgender person’s physical appearance and function of their existing sexual characteristics are altered to resemble that socially associated with their identified gender. It is part of a treatment for transgender / gender diverse (TGD) in transgender people.

Transgender / Gender Diverse (TGD) Transgender / gender diverse (TGD): (1) Discontent with the physical or social aspects of one's own sex. (2) In *DSM-5*, a diagnostic class that replaces gender identity disorder and shifts clinical emphasis from cross-gender identification itself to a focus on the possible distress arising from a sense of mismatch, or incongruence, that one may have about one's experienced gender versus one's assigned gender. Diagnostic criteria for transgender / gender diverse (TGD) in children include significant distress or impairment due to marked gender incongruence, such as a strong desire to be-or a belief that one is-the other gender; preference for the toys, games, roles, and activities stereotypically associated with the other gender, and a strong dislike of one's sexual anatomy. In adults, the manifestations of transgender / gender diverse (TGD) may include a strong desire to replace one's physical sex characteristics with those of the other gender (see *SEX REASSIGNMENT*), the belief that one has the emotions of their gender, and a desire to be treated as the other gender or recognized as having an alternative gender identity.

QUALIFIED MENTAL HEALTH PROFESSIONAL

Qualified Mental Health Professional: A mental health professional who diagnoses and treats adults presenting for care regarding their gender identity or transgender / gender diverse (TGD) and who possess the following minimum credentials, as recommended in the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7:1

1) A master's degree or equivalent in a clinical behavioral science field from an institution accredited by the appropriate national accrediting board and is licensed by the relevant licensing board to practice in the Commonwealth of Pennsylvania.
2) Competence in using the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders for diagnostic purposes.
3) Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from transgender / gender diverse (TGD). Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of transgender / gender diverse (TGD)
4) Documented supervised training and competence in psychotherapy or counseling.
5) Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of transgender / gender diverse (TGD).
6) Continuing education in the assessment and treatment of transgender / gender diverse (TGD). This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental

health professional with relevant experience; or participating in research related to gender nonconformity and transgender / gender diverse (TGD).

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

For Jefferson Health Plans EverWell and Jefferson Health Plans CHIP products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2026 Addition to product variation statement.	I	10/29/2026
2025 Annual Review. Revisions to terminology, Policy Statement and Coding sections. References updated.	I	12/17/2025
October 2024 ad-hoc review. Coverage criteria revised.	H	12/18/2024
July 2024 ad-hoc review. Product variation section updated to include coverage for all lines of business.	G	07/19/2024
2024 Annual review. CPT code 19318 (Breast reduction) was added to the coding table.	F	05/15/2024
2023 Annual review. Minor change. Nipple reconstruction removed from non-covered section.	E	05/01/2022
2022 Annual review. Added to covered services: Gender specific services for the transgender community. Added to non-covered services: More than one breast augmentation	E	05/01/2022

Summary	Version	Version Date
2021 Annual review. The following was added to the non-covered section of the policy: facial feminization surgery, masculinization surgery, procedures for the preservation of fertility. The following codes were added to the coding table: 89258, 89335, 89337, 89342, 89344, 89346, 89352, 89354, 89398, S4030 & S4040.	D	07/01/2021
2020 Annual review. Language was added to the policy statement to enhance readability.	C	09/01/2020
2019 Annual review. No revisions to this version.	B	07/18/2018
2018- Modifications made to enhance readability and clarify intent, including addition of definitions. New codes added.	B	07/18/2018
New policy.	A	11/06/2016

REFERENCES

1) The World Professional Association for Transgender Health (WPATH). Standards of Care https://wpath.org/publications/soc8/chapters/

2) The World Professional Association for Transgender Health (WPATH) https://wpath.org/wp-content/uploads/2024/11/WPATH-Position-on-Medical-Necessity-12-2016.pdf

3) American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, Fifth Edition, Arlington, Virginia: American Psychiatric Association.

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7) Mass.gov. "Guidelines for Medical Necessity Determination for Gender Reassignment Surgery."https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-gender-affirming-surgery .

8) Centers for Medicare & Medicaid Services (CMS). *National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9)*. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=368&ncdver=1&DocID=140.9&bc=gAAAABAAAAAA&

9) Guidelines for Medical Necessity Determination for Gender Reassignment Surgery. MassHealth. https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-gender-affirming-surgery

10) Wikipedia (Gender confirmation surgery definition): https://en.wikipedia.org/wiki/Sex_reassignment_surgery

11) 2018 American Psychological Association (Gender Dysphoria definition): https://www.apa.org/monitor/2018/09/ce-corner-glossary