

Clinical Policy: FEHBP Gender Reassignment Surgery

Reference Number: QCP.CP.037

Last Review Date: 10-7-25

[Coding Implications](#)

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Description

This policy is specific to the Federal Employees Health Benefits.

Policy/Criteria

- I. It is the policy of QualChoice Health plan that gender reassignment surgery is medically necessary and require preauthorization. In order for coverage to be authorized, ALL of the following criteria must be met:
 - a. The member is 18 years of age or older.
 - b. The member has a definitive diagnosis of persistent gender dysphoria that has been made and documented by a qualified mental health professional.
 - c. The member has received continuous hormone therapy for 12 months or more under the supervision of a physician.
 - d. The member has lived as their reassigned gender full-time for 12 months or more.
 - e. At least two different mental health professionals, not working in the same group or otherwise associated with each other, have evaluated the member and recommended gender reassignment surgery as medically necessary. At least one of the mental health professionals must be a psychiatrist or clinical (PhD) psychologist.
 - f. The member's medical and mental health providers document that there are no contraindications to the planned surgery and agree with the plan, within three months of the prior authorization request.
- II. For male-to-female procedures, the following surgeries may be authorized: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, vulvoplasty, mammoplasty, prostatectomy, urethroplasty
- III. For female-to-male procedures, the following surgeries may be authorized: mastectomy, hysterectomy, salpingectomy, oophorectomy, vaginectomy, vulvectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, testicular prosthesis implantation.
- IV. QualChoice does not cover reversal of any of the above procedures.
- V. The following procedures are not considered necessary to gender reassignment, and so are considered cosmetic (not an all-inclusive list): blepharoplasty, rhinoplasty, rhtidectomy, osteoplasty, genioplasty, penile prosthetic implantation, reduction thyroid chondroplasty, and any other procedures designed to alter appearance

- VI. Procurement, cryopreservation, and storage of sperm, oocytes, or embryos are not considered medically necessary and are not covered

Background

Gender reassignment surgery, also called sexual reassignment surgery, encompasses those procedures that are intended to reshape a male body into a body with female appearance, or vice versa. Gender reassignment surgery is part of a treatment plan for gender dysphoria.

Gender dysphoria is defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and the person's assigned sex at birth, including the associated gender role and/or primary and secondary sex characteristics.

Gender reassignment surgery is intended to be a permanent change, establishing congruency between an individual's gender identity and physical appearance, and is not easily reversible. A careful and accurate diagnosis is essential for treatment and can only be made with a long-term diagnostic process. A patient's self-assessment and desire for sex reassignment cannot be considered reliable indicators of gender dysphoria, or adequate predictors of success in treatment.

Prior to gender reassignment surgery, patients generally undergo prolonged hormone therapy. Lifelong maintenance is usually required, even after surgery. Prior to undergoing irreversible surgery, the individual is also expected to undergo what is referred to as "real life experience," in which s/he adopts the new or evolving gender role and lives in that role continuously as part of the transition. This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, and the adequacy of her/his support system. During this time, the individual would be expected to maintain the functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Coding Implications

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CPT® Codes	Description
19303	Mastectomy, simple, complete
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), w/ or w/out testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
57291	Construction of artificial vagina; w/out graft
57292	Construction of artificial vagina; w/graft
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), w/ or w/out removal of ovary(s)
58262	Vaginal hysterectomy, for uterus 250 g or less; w/removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250 g; w/removal of tube(s), and/or ovary(s)
58552	Laparoscopy, surgical, w/vaginal hysterectomy, for uterus 250 g or less; w/removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, w/vaginal hysterectomy, for uterus greater than 250 g; w/removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, w/total hysterectomy, for uterus 250 g or less; w/removal of tube(s) and/or ovary(s)
58573	Laparoscopy, surgical, w/total hysterectomy, for uterus greater than 250 g; w/removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; w/removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58999	Unlisted procedure, female genital system (non-obstetrica)l

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review Date	10-7-25	

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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