Gender-conforming facial surgery

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Coverage policy

Gender-conforming facial surgery for transgender members is investigational/not clinically proven and, therefore, not medically necessary (World Professional Association for Transgender Health, 2012).

Limitations

No limitations were identified during the writing of this policy.

Alternative covered services

No alternative covered services were identified during the writing of this policy.

Background

Gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person’s gender identity and their sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Knudson, 2010). Gender dysphoria differs from gender nonconformity, defined as a person’s gender identify, role, and expression differing from cultural norms of a particular sex (Institute of Medicine, 2011).

The prevalence of gender dysphoria in populations may vary by level of cultural and social acceptance in each nation. Moreover, most estimates that have been made are from European nations. Prevalence of self-reported
transgender identity in children, adolescents, and adults ranges from 0.5% to 1.3%, which is considerably greater than estimates based on clinic-referred adult samples (Zucker, 2017). During the past 50 years, reported prevalence has increased; current estimated prevalence, based on 12 studies, is 6.8 and 2.6 per 100,000 for transwomen and transmen, respectively (Arcelus, 2015).

Gender reassignment for those with dysphoria typically include surgery, hormone therapy, and psychotherapy. Not all persons with gender dysphoria will undergo surgery. Of those who do, surgical procedures generally include (for transwomen) facial feminization surgery, voice surgery, breast augmentation, orchiectomy, and vaginoplasty, and (for transmen) facial masculinization surgery, subcutaneous mastectomy, and phalloplasty (Colebunders, 2017).

Gender-conforming facial surgery can be performed for masculinization or feminization as part of gender reassignment. The most common types of facial feminization procedures include forehead contouring, blepharoplasty, cheek augmentation, chin width reduction (genioplasty), lip lift/augmentation, mandibular angle reduction, and rhinoplasty (Mayo Clinic, 2019). Common facial masculinization procedures include cheek augmentation, chin recontouring, forehead lengthening/augmentation, jaw contouring rhinoplasty, and thyroid cartilage (Adam’s apple) enhancement (The International Center for Transgender Care, 2019).

Findings

The World Professional Association for Transgender Health has issued Standards of Care; the latest (seventh) version was published in 2012. The standards state that plastic and reconstructive surgeries usually have no clear distinction whether they are cosmetic or reconstructive, and are usually labeled “purely aesthetic.” Criteria for when these (including gender-conforming facial surgeries) should be performed are not included (World Professional Association for Transgender Health, 2012). Other guidelines, often written by mental health professional groups, do not address gender-conforming facial surgery.

Federal regulators published a decision memo for gender dysphoria and gender reassignment surgery, rather than issue a National Coverage Determination, due to lack of evidence for the Medicare population (Centers for Medicare & Medicaid Services, 2016).

A systematic review of 15 articles (n = 1,121) about transgender women who underwent facial feminization procedures reported just seven cases with complications (not all articles addressed complications) and generally high patient satisfaction (Morrison, 2016).

A study of 802 persons showed that over 99% of cis-gender males and females were identified with the correct gender. Among those who were going through gender reassignment from male to female, the gender of persons was identified correctly in 57.31% of cases prior to facial feminization surgery, and 94.27% after facial feminization surgery (Fisher, 2019).

A study of 247 male-to-female transgendered individuals included 30.3% (n = 75) who underwent facial feminization surgery with or without primary sex trait reassignment surgery. The article revealed that the mental health quality-of-life index was statistically higher (P < 0.01) among those who underwent facial feminization surgery than those who did not (Ainsworth, 2010).

For various reasons, facial surgery is not performed as frequently in the transgender population. In one study of 99 persons (71 transwomen and 28 transmen) who received treatment between 2004 and 2015, only 8%
had facial surgery, compared to chest surgery (25%) and genital surgery (13%) (Kailas, 2017). A contrary view is offered in an article which states that transsexual women undergo facial feminization surgery before undergoing any other surgery as a means of easing their social transition (Altman, 2012).

Studies from Europe also reveal facial surgery in transsexual women is not a common practice. A review of 193 Spanish persons with gender dysphoria, 119 of whom are transsexual women, report that only 11 (9.2% of 119) received facial feminization (Gomez-Gil, 2014). A quality of life study from the Netherlands consisting of 140 transgender persons showed that just 14 had facial feminization (Motmans, 2011).

The consensus opinion that facial feminization surgery is cosmetic is not shared by some. One disagreement is based on the premise that the desired degree of feminization is impossible to achieve through soft tissue procedures alone, since bone structure provides the architecture of facial sex differences (Altman, 2012).

In a study of 61 insurance companies, the proportion that reported covering facial procedures as part of gender dysphoria treatment was between 8% and 26% (Ngaage, 2019).

References

On January 21, 2020, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “Facial feminization surgery,” “facial masculinization surgery,” “gender dysphoria,” “gender reassignment,” and “gender conforming surgery.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.


**Policy updates**

3/2020: initial review date and clinical policy effective date: 4/2020
3/2020: no updates made to policy.