Annual Effective Date: January 1, 2026
Original Effective Date: January 1, 2024

Related Medical Policies:
None

Facial Sex Trait Modification Surgery

DESCRIPTION

Facial sex trait modification surgery (formerly known as: gender affirming surgery (FGAS)) is a subset of gender affirming care to treat gender dysphoria. FGAS is described as surgical procedures done to feminize or masculinize facial features to align with gender identity [1].

OBJECTIVE

The objective of this guideline is to identify when the services are eligible for reimbursement to facilitate the delivery of quality care for facial gender affirming surgery, specific to feminization, masculinization, or non-binary transition.

This guideline does not override contractual requirements of the benefit provisions as outlined in the Blue Cross and Blue Shield federal brochures (RI-71005/Standard and Basic Option[2] and RI 71-017/FEP Blue Focus). This document is not intended to replace medical judgment of a physician for treatment.

COVERED PROVIDERS

Healthcare professionals must be licensed, certified, or registered for the services provided as applicable by state/federal licensing regulations.

For Members enrolled in Basic Option and FEP Blue Focus: Preferred providers must be used in order to receive benefits. See the assigned federal brochures (RI 71-005/Standard and Basic Option and RI 71-017/FEP Blue Focus) for exceptions.

For Members enrolled in Standard Option: Preferred provider and non-preferred provider benefits apply.

UM GUIDELINE

*All requirements for **sex trait modification surgery** must be met to access facial sex trait modification surgery benefits.*

- **Sex Trait Modification surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved, and your provider later modifies the plan subject to the pre-surgical requirements listed below. **The member must meet all requirements**.
  - Prior approval is obtained.
  - Member must be at least 16 years of age for mastectomy and 18 years of age for other covered surgeries at the time prior approval is requested and the treatment plan is submitted.
- Diagnosis of gender dysphoria by a qualified healthcare professional with well-documented persistent gender incongruence, including documentation that other possible causes of gender incongruence have been excluded.
  - Member must meet the following criteria:
    - 6 months of continuous hormone therapy appropriate to the member's gender identity (unless medically contraindicated and hormone therapy is not required for mastectomy)
    - Documentation of informed consent and fulfillment of the program's criteria for gender affirming surgical treatment
    - Must have a written psychological assessment from a qualified mental health professional documenting the diagnosis of persistent gender dysphoria with a

well-documented persistent gender incongruence between the assigned gender and the experienced/expressed gender or some alternative gender, support of surgical procedure(s), and well-controlled physical and mental health conditions.
    - Surgical treatment plan must include timing, technique, and duration of aftercare.

- **Facial Sex Trait Modification Surgery (FSTMS) benefits are available for members who have met the criteria for sex trait modification surgery (*gender affirming*). For FSTMS, the following additional requirements must be provided** [3]**:**
    - Documentation is required from a professional (e.g., surgeon, primary care provider, mental health clinician) who has evaluated the member or has been treating the member, that the proposed revision is expected to improve the member's feminine, masculine, or non-binary appearance, whichever is appropriate, and, that the revision is expected to decrease the member's gender dysphoria **AND**
    - The surgery or procedure is not for the purpose of reversing the appearance of aging **AND**
    - The surgery or procedure is specific to feminization, masculinization, or non-binary transition, and would not be pursued for other reasons, e.g., to improve appearance or to correct medical or surgical problems unrelated to feminization, masculinization, or non-binary transition **AND**
    - At least one pre-surgery evaluation by the surgeon (in-person or virtual) with documentation of medical contraindication to surgery as discussed with the member**,** or of any necessary medical evaluations or treatment or clearance prior to surgery, or of any healthcare action that is necessary (e.g., weight loss) prior to surgery.
        - For prospective requests, this evaluation must have been done within the last 6 months.
        - For retrospective requests, this evaluation must have been done within the 6 months immediately preceding the surgery **AND**
    - The surgery or procedure is primarily intended for, and is expected to result in, a more feminine or masculine or nonbinary appearance **AND**
    - The surgery or procedure is not for the purpose of reversing the appearance of aging **AND**
    - The surgery or procedure is specific to feminization, masculinization, or non-binary transition, and would not be pursued for other reasons, e.g., to improve appearance or to correct medical or surgical problems unrelated to feminization, masculinization, or non-binary transition (however, if potentially indicated for other reasons, the surgery or procedure might be covered under a different benefit; refer to member contract language) **AND**
    - The surgery or procedure is not being pursued for the purpose of enhancing features which are already clearly recognizable as feminine, masculine, or non-binary.

- **Covered facial sex trait modification surgeries and procedures such as the following:**
    - **For female to male surgery**:
        - forehead lengthening
        - cheek augmentation
        - rhinoplasty
        - jaw reshaping
        - chin contouring
        - Adam's apple enhancement (thyroid cartilage enhancement or implant)
        - pitch lowering masculinization voice surgery
        - cosmetic fillers
        - botulinum toxin

        - fat grafting
        - liposuction
    - **For male to female surgery**:
        - chondrolaryngoplasty
        - rhinoplasty
        - contouring or augmentation
            - of the jaw
            - chin, and forehead
        - facelift
        - hair removal and transplantation
        - pitch raising surgery/Wendler glottoplasty
        - cosmetic fillers
        - botulinum toxin
        - fat grafting and liposuction.

    - Examples of complications that may require what is considered **Medically Necessary** intervention according to FEHPB after FSTM surgery include but are not limited to:
        - Suture rupture along an incision line
        - Solid swelling of clotted blood within the tissues
        - Infection
        - Functional impairment
    - Not covered:
        - Modification or enhancement of original FGAS to the desired appearance

    "Medical necessity shall mean healthcare services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:
        - In accordance with generally accepted standards of medical practice in the United States; **AND**
        - Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; **And**
        - Not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; **And**
        - Not part of or associated with scholastic education or vocational training of the patient; **And**
        - In the case of inpatient care, able to be provided safely only in the inpatient setting.
- For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations. The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed,

recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan." [11,12]

PLEASE NOTE: Revision of appearance after previous sex trait modification surgery due to dissatisfaction with the outcome or to modify or enhance the desired appearance**, in the absence of pain, functional impairment, or infection**, are considered cosmetic and non-covered.

Note: Prior approval must be obtained for the surgical services and precertification must be obtained for any inpatient facility stay. We also provide the benefits seen here when billed by a facility.

References

1. Juszczak, H.M., Fridirici, Z.C., Knott, P.D., Park, A.M., & Seth, R. (2019). An update in facial gender confirming surgery. *Current Opinion in Otolaryngology & Head & Neck Surgery*.
2. 2025 Blue Cross ® and Blue Shield ® Service Benefit Plan Brochure
3. Premera Blue Cross Corporate Medical Policy: Gender Transition/Affirmation Surgery and Related Services. Last revised. October 21, 2024. Retrieved from https://www.premera.com/medicalpolicies/7.01.557.pdf.
4. Berli, J. U., Capitan, L., Simon, D., Langner, R. B., Plemons, E., & Morrison, S. D. (2017). *Facial gender confirmation surgery-review of the literature recommendations for Version 8 of the WPATH Standards of Care.* Retrieved from International Journal of Transgenderism 18.3, 264-270: DOI: 10.1080/15532739.2017.1302862
5. Bonapace-Potvin, M., Pepin, M., Navals, P., Maria, C. M., Elisabeth, L., & Eric, B. (2022). *Facial Gender-Affirming Surgery: Frontal Bossing Surgical Techniques, Outcomes and Safety. Aesthetic Plastic Surgery.* Retrieved from PubMed: https://doi.org/10.1007/s00266-022-03180-3
6. *Facial Feminization*. (2023, June 29). Retrieved from https://www.facialfeminization.net/facial-feminization-surgery-wpath-standards-of-care.htm
7. J.C., D.-B. (2019). Approach to Feminization Surgery and Fascial Masculinzation Surgery: Aesthetic Goals and Principles of Managment. . *The Journal of craniofacial surgery,30(5)*, 1352-1358 https://doi.org/10.1097/SCS.0000000000005391.
8. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. Nov 1 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658. Retrieved July 2023 from: https://www.endocrine.org/advocacy/position-statements/transgender-health
9. Fenway Health. Medical Care of Trans and Gender Diverse Adults. Reviewed December 1,2025 from: https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021
10. American Society of Plastic Surgeons. Reviewed November 30, 2025 from: https://www.plasticsurgery.org/reconstructive-procedures/facial-feminization-surgery/safety
11. 2025 Blue Cross ® and Blue Shield ® Service Benefit Plan Brochure (RI 71-005)
12. 2025 Blue Cross ® and Blue Shield ® Service Benefit Plan Brochure FEP ® Blue Focus Brochure (RI 71-017)

HISTORY

Date	Action	Description
Dec 2023	New guideline	UM Guideline for Facial Gender Affirming Surgery
Dec 2024	Replace Guideline	Guideline updated with literature review through November 18, 2024; references updated. Coverage statement unchanged.
Dec 2025	Replace Guideline	Title changed to Facial Sex Trait Modification Surgery.