Oscar Clinical Guideline: Gender-Affirming Services (CG017, Ver. 17)

Gender-Affirming Services

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

Gender dysphoria is a condition characterized by clinically significant distress associated with incongruence between an individual's gender identity and sex assigned at birth. The Plan follows the World Professional Association for Transgender Health (WPATH) guideline standards to determine the appropriate medical necessity criteria and support we can provide for our members. Therefore, the Plan considers gender-affirming services medically necessary for members with documented gender dysphoria who meet the criteria in this guideline. Please see your plan benefit and pharmacy policies for hormone therapy.

If the member is requesting infertility services due to iatrogenic infertility as a result of gender-affirming services, please refer to the Plan Clinical Guideline: Diagnosis and Treatment of Infertility (CG016). Please refer to the member's benefit plan for eligibility for infertility services.

Definitions

"Augmentation mammaplasty" or "Breast augmentation" is a surgical procedure to enlarge one or both breasts.

"Aesthetic surgery" refers to surgery that is not performed for functional reasons but instead to modify the appearance of an individual. In the context of gender dysphoria, the purpose is to better approximate the desired gender identity. This is contrasted from cosmetic surgery, where the procedures may overlap with those categorized as "aesthetic", but the intent is not to treat gender dysphoria.

"Eunuch" individuals are those assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning. They also include those whose testicles have been surgically removed or rendered nonfunctional by chemical or physical means and who identify as a eunuch.

"Gender identity" is a person's innate, deeply-felt sense of being a man, woman, or neither, which may or may not correspond to the sex listed on a person's birth certificate. Despite this, "gender" is often assigned synonymously with "sex" at birth. Furthermore, "gender" most often coincides with "identity" but can be expressed differently through behaviors, clothing, hairstyles, etc. (e.g., someone can identify as male but express their gender as female).

"Gender dysphoria" describes a state of distress or discomfort that may be experienced because a person's gender identity differs from that which is physically and/or socially attributed to their sex assigned at birth. Gender dysphoria is also a diagnostic term in the DSM-5 denoting an incongruence between the sex assigned at birth and experienced gender accompanied by distress. Not all transgender and gender diverse people experience gender dysphoria.

"Gender incongruence" is no longer seen as pathological or a mental disorder in the world health community, while gender dysphoria is a mental health condition diagnosed by Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Gender incongruence is recognized as a condition in the International Classification of Diseases and Related Health Problems, 11th Version of the World Health Organization (ICD-11) (not yet adopted in the U.S.).

"Gender nonconforming" describes people whose gender expression is neither masculine, nor feminine, or is different from traditional or stereotypic expectations of how a man or a woman should appear or behave.

"Hormone therapy" is the administration of exogenous endocrine agents to induce feminizing or masculinizing bodily changes, such that a person can more closely approximate the physical appearance of the genotypically other sex.

"Non-binary gender" or "genderqueer" describes people whose gender expression is neither masculine, nor feminine, including people who identify with no gender or with more than one gender.

"Sex" is a term for a person's biological and physical characteristics and is typically assigned at birth. It differs from gender in that it is an outward, physical characteristic where gender is a psychological, emotional, and social identity.

"Sexual orientation" refers to a person's preferences of attraction or lack thereof with others.

"Sex reassignment surgery" or "gender affirmation surgery" refers to surgery that alters the morphology to approximate the physical appearance of the genetically other sex (male-to-female, or female-to-male).

"Transsexual" refers to individuals whose sex differs from the sex listed on his/her original birth certificate and has had or wishes to have gender reassignment surgery (GRS), or who receives hormone therapy but does not wish to have GRS (nonoperative transsexuals), and lives full-time in his/her new gender role.

"Transgender and gender diverse (TGD)" is a broad term to include as many members of varied communities around the world with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth.

"Male-to-female genital reassignment surgery" includes, but is not limited to, the following procedures:

- "Cliteroplasty" is the surgical creation or alteration of a clitoris
- "Electrolysis" for hair removal is a procedure to permanently remove hair on skin used with gender affirmation procedures.
- "Orchiectomy" is the surgical removal of one or both testicles.
- "Penectomy" is the surgical removal of the penis.

- "Urethroplasty" is the surgical alteration and revision of the urethra.
- "Vaginoplasty" is the surgical procedure that results in the construction or reconstruction of the vagina.
- "Vulvoplasty" is the surgical repair or remodeling of the vulva.

"Female-to-male genital reassignment surgery" includes the following procedures:

- "Bilateral salpingo-oophorectomy" is the removal of both ovaries and fallopian tubes.
- "Electrolysis" for hair removal is a procedure to permanently remove hair on skin used with gender affirmation procedures.
- "Hysterectomy" is the surgical removal of all or part of the uterus.
- "Mastectomy" is the surgical removal of the whole breast. There are several different techniques with varying aesthetic outcomes. For example, "Subcutaneous mastectomy" is the removal of the breast but leaving the nipple-areolar complex.
- "Metoidioplasty" is a female-to-male gender reassignment surgery where the clitoris is released so that it stands in a more forward position, with or without urethral lengthening.
- "Oophorectomy" is the surgical removal of one or both ovaries.
- "Phalloplasty" is the construction or reconstruction of a penis.
- "Salpingectomy" is the surgical removal of one or both fallopian tubes.
- "Scrotoplasty" is the construction or reconstruction of a scrotum.
- "Vaginectomy" is a surgical procedure to remove all or part of the vagina.
- "Vulvectomy" is a procedure in which the vulva is partly or completely removed.

Medical Necessity Criteria for Clinical Review

General Medical Necessity Criteria

(Please check the member's plan benefits)

Gender-affirming services are considered medically necessary when ALL the following are met:

1. Member has capacity to grant fully informed consent for treatment and associated risks; *and*
2. Member has persistent, well-documented gender dysphoria or gender incongruence; *and*
3. Member has received a mental health screening and assessment with documentation from one qualified health professional as part of a multidisciplinary team for gender-affirming procedures, defined by ALL of the following:
    a. A psychiatrist (MD or DO), psychologist (PhD or Masters), clinical social worker (LCSW) in collaboration with a psychiatrist or psychologist, or other practitioner (MD, DO, PA, or NP) who is licensed by their statutory body and specialized in transgender medicine; *and*
    b. Proficiency in using the Diagnostic Statistical Manual of Mental Disorders (DSM-5); *and*
    c. Experience with or specialized in diagnosing and treating gender dysphoria or gender incongruence; *and*
4. If significant medical or mental health concerns are present, they must be reasonably well controlled or under treatment; *and*
5. Other possible causes of apparent gender dysphoria or gender incongruence have been excluded.

Adolescent-Specific Criteria

For adolescents, gender-affirming services are considered medically necessary when ALL of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. A comprehensive biopsychosocial assessment should be completed with mental health and/or medical professionals as part of a multidisciplinary team; *and*
3. Member has adequate home support and involvement of parent(s)/guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible; *and*
4. Member has realistic expectations regarding the possibilities and limitations of gender-affirming services and a full understanding of the long-term consequences of gender-affirming services; *and*
5. Member has been evaluated for safety, has been assessed for any co-existing mental health concerns, and is not requesting surgery as an initial response to gender dysphoric puberty.

Indication-Specific Criteria

Gonadectomy, Hysterectomy, and Salpingo-Oophorectomy

Adults

Gonadectomy (oophorectomy or orchiectomy), hysterectomy, salpingo-oophorectomy, for the treatment of gender dysphoria are considered medically necessary when ALL of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. Age of majority (18 years or older); *and*
3. 1 evaluation from a qualified health care professional, who has competencies in the assessment of transgender and gender diverse people, and is part of the multidisciplinary team managing the medical and mental health of the member; *and*
4. Member has tolerated at least 6 months of continuous hormone therapy, unless contraindicated or inconsistent with the member's goals of gender identity; *and*
5. Reproductive options or fertility preservation have been discussed prior to gonadectomy (oophorectomy or orchiectomy), hysterectomy, salpingo-oophorectomy; *and*
6. Member will be managed by a multidisciplinary team, risks and benefits discussed prior to surgery, understands aftercare requirements and follow-up assessments post-surgery.

Genital Reconstruction

Adults

Genital reconstruction procedures (cliteroplasty, urethroplasty, vaginoplasty, vulvoplasty, labiaplasty, phalloplasty with or without penile prosthesis, scrotoplasty with or without scrotal prosthesis, or metoidioplasty) for the treatment of gender dysphoria are considered medically necessary when ALL of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. Age of majority (18 years or older); *and*

3. 1 evaluation from a qualified health care professional, who has competencies in the assessment of transgender and gender diverse people, and is part of the multidisciplinary team managing the medical and mental health of the member; *and*
4. Member has tolerated at least 6 months of continuous hormone therapy, unless contraindicated or inconsistent with the member's goals of gender identity; *and*
5. Reproductive options or fertility preservation have been discussed prior to genital reconstruction; *and*
6. Member will be managed by a multidisciplinary team, risks and benefits discussed prior to surgery, and follow-up assessments post-surgery.

Breast/Chest Procedures

Adults

Breast procedures (female-to-male mastectomy or male-to-female breast augmentation) for the treatment of gender dysphoria is considered medically necessary when ALL of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. Age of majority (18 years or older); *and*
3. 1 evaluation from a qualified health care professional, who has independently assessed the individual, but is part of the multidisciplinary team managing the member; *and*
4. Breast cancer risk factors have been assessed prior to breast augmentation or mastectomy, including the anticipated amount of remaining breast tissue; *and*
5. Member will be managed by a multidisciplinary team, risks and benefits discussed prior to surgery, and follow-up assessments post-surgery.

Adolescents

Gender-affirming services for adolescents may be eligible and subject to plan benefits. Members less than the age of majority will be considered on a case-by-case basis for medical necessity for breast/chest procedures when BOTH of the following criteria are met:

1. Adolescent-Specific Criteria are met; *and*
2. Member has tolerated at least 12 months of gender-affirming hormone therapy or longer, unless contraindicated or inconsistent with the member's goals of gender identity.

Revision Surgery

Adults

Revision surgery may be considered medically necessary when ALL of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. Requests for revision surgery must be submitted with medical records demonstrating objective examination; *and*
3. ONE of the below:
    a. To treat complications resulting from the initial surgery; *or*
    b. To correct dysfunction resulting from the initial surgery; *or*

c. If, after the initial surgery, the appearance of the transgender body part is still outside the normal variation in appearance of the member's gender identity. Additional requests to enlarge breasts or penile girth or length beyond the original intended procedure is considered NOT medically necessary.

Adolescents

Gender-affirming services for adolescents are subject to plan benefits. Members less than the age of majority will be considered on a case-by-case basis for medical necessity for revision surgery when ONE of the following criteria is met:

1. Adolescent-Specific Criteria are met.

Non-Surgical Services

Non-surgical services are considered medically necessary when BOTH of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. ONE of the below:
    a. Psychotherapy to support the member through his/her gender transition; *or*
    b. Vocal training with a speech language pathologist; *or*
    c. Laboratory testing to monitor the safety and effectiveness of continuous gender-affirming hormone therapy (GAHT) therapy and/or puberty-suppressing hormone therapy; *or*
    d. Breast cancer screening for female to male trans-identified individuals who have not undergone a mastectomy; *or*
    e. Prostate cancer screening for male to female trans-identified individuals who have retained their prostate; *or*
    f. Hair removal or electrolysis for skin used for genital reconstruction as part of gender affirmation surgery performed by a licensed and/or certified provider.

Continuous Hormone Therapy

(Please refer to your pharmacy benefit and pharmacy guidelines for self-administered hormone therapy)

The Plan considers hormone therapy for gender dysphoria or gender incongruence before and/or after gender affirmation surgery to be medically necessary when ONE of the following criteria is met:

1. Gender-affirming hormone therapy (GAHT) in adults (age of majority) who are transitioning for the member's gender congruence goals, when ALL of the following are met:
    a. General Medical Necessity Criteria are met; *and*
    b. Fertility preservation counseling has been provided prior to initiation of therapy; *and*
    c. The requested medication has been prescribed by a qualified healthcare professional for persistent, well-documented gender dysphoria or gender incongruence; *or*
2. Puberty-suppressing hormone therapy in adolescents for the member's gender congruence goals, when ALL of the following are met:
    a. Adolescent-Specific Criteria are met; *and*
    b. Fertility preservation counseling has been provided prior to initiation of therapy; *and*

c. The requested medication has been prescribed by a qualified healthcare professional for persistent, well-documented gender dysphoria or gender incongruence; *and*
d. The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated; *and*
e. The adolescent has given informed consent and, when the adolescent has not reached the age of medical consent, the parent(s)/guardian(s) have consented to the treatment and are involved in supporting the adolescent throughout the treatment process; *or*

3. Gender-affirming hormone therapy (GAHT) in adolescents, when ALL of the following are met:
    a. Adolescent-Specific Criteria are met; *and*
    b. Fertility preservation counseling has been provided prior to initiation of therapy; *and*
    c. The requested medication is prescribed by a qualified healthcare professional for persistent, well-documented gender dysphoria or gender incongruence; *and*
    d. The adolescent demonstrates sufficient emotional and cognitive maturity to provide informed consent for treatment and associated risks; *and*
    e. The adolescent has given informed consent and, when the adolescent has not reached the age of medical consent, the parent(s)/guardian(s) have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Elective Reversal of Gender-Affirming Services/Surgery

1. The Plan considers reversal of previous gender-affirming surgery, hormone therapy, and services as medically necessary on a case-by-case basis to assist in detransition.

State Law Conflicts

For any provision of this policy that directly conflicts with or is prohibited by state law, the provisions of the state law will apply instead of the provisions of this policy. This means that in instances where state regulations diverge from or directly oppose the Plan Clinical Guideline: Gender-Affirming Services, the policy's criteria will not apply.

Experimental, Investigational, or Unproven / Not Medically Necessary

Drugs or Services to Treat Sexual Dysfunction

Drugs or services to treat sexual dysfunction are not considered medically necessary to treat gender dysphoria.

Cosmetic Services

Certain services may be considered cosmetic for the treatment of gender dysphoria services, as the service is intended to enhance features rather than to correct an anatomical deformity or variation that is outside the spectrum of normal for the desired gender. Furthermore, any procedure for the purpose of improving appearances such as rejuvenating procedures to look younger, or altering natural traits for the intent of beautification are considered cosmetic. Therefore, the following services are considered not medically necessary, including but not limited to the following:

1. Abdominoplasty

2. Blepharoplasty
3. Body contouring, such as masculinization of the torso and pectoral implants, lipofilling, liposuction.
4. Botulinum toxin injections
5. Brow or forehead lift
6. Calf implants
7. Cheek, chin or nose implants
8. Facial feminization, including face lifts, jaw and facial bone reduction, and neck tightening
9. Gluteal augmentation
10. Hair removal for any other location or indication outside of what is noted above in Non-Surgical Services
11. Hair transplantation
12. Lip augmentation, enhancement or reduction
13. Liposuction (e.g., suction assisted lipectomy)
14. Mastopexy
15. Panniculectomy
16. Rhinoplasty
17. Revision or reconstruction surgery, if the request is primarily cosmetic nature, not satisfied with the surgical result, to reverse natural signs of aging, and/or if the criteria above is not otherwise met
18. Skin resurfacing or removal of redundant skin, except when a direct result of a medically necessary surgery
19. Speech therapy not provided by a speech language pathologist, as it is considered experimental or investigational
20. Speech therapy performed in a group setting, as it is considered experimental or investigational
21. Thyroid chondroplasty / chondrolaryngoplasty or cartilage reduction (commonly referred to as "tracheal shave" of the Adam's apple)
22. Voice modification surgery (e.g., laryngoplasty)

Applicable Billing Codes

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander(s) without insertion of implant
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
11981	Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less ● Due to multiple body parts represented by this code, clarification is provided below: ● When billed for genital reconstruction, it is considered medically necessary
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm ● Due to multiple body parts represented by this code, clarification is provided below: ● When billed for genital reconstruction, it is considered medically necessary
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
15201	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less ● Due to multiple body parts represented by this code, clarification is provided below: ● When billed for genital reconstruction, it is considered medically necessary
15241	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) ● Due to multiple body parts represented by this code, clarification is provided below: ● When billed for genital reconstruction, then it is considered medically necessary
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15750	Flap; neurovascular pedicle
17380	Electrolysis epilation, each 30 minutes ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When billed for hair removal indicated for genital reconstruction, it is considered medically necessary. When billed for any other body part, it is considered NOT medically necessary.
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
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
54120	Amputation of penis; partial
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
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
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

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy, complete removal of vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
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 g 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
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)
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)

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; 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)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
82670	Estradiol; total
83002	Gonadotropin; luteinizing hormone (LH)
84153	Prostate specific antigen (PSA); total

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
84402	Testosterone; free
84403	Testosterone; total
90785	Interactive complexity (List separately in addition to the code for primary procedure)
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
A4280	Adhesive skin support attachment for use with external breast prosthesis, each
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
J1071	Injection, testosterone cypionate, 1 mg
J1073	Testosterone pellet, implant, 75 mg
J1380	Injection, estradiol alerate 10mg IM
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J3121	Injection, testosterone enanthate, 1 mg
J3145	Injection, testosterone undecanoate, 1 mg
J3315	Injection, triptorelin pamoate, 3.75 mg
J3316	Injection, triptorelin, extended-release, 3.75 mg
J9202	Goserelin acetate implant, per 3.6 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219	Leuprolide acetate implant, 65 mg
J9225	Histrelin implant (Vantas), 50 mg
J9226	Histrelin implant (Supprelin LA), 50 mg
L8000	Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy
L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal, without integral adhesive
L8031	Breast prosthesis, silicone or equal, with integral adhesive
L8032	Nipple prosthesis, prefabricated, reusable, any type, each
L8039	Breast prosthesis, not otherwise specified

Table 1	
Gender-Affirming Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
L8600	Implantable breast prosthesis, silicone or equal

Table 2	
ICD-10 codes considered medically necessary with Table 1 codes if criteria are met:	
Code	*Description*
F64.0	Transexualism ● Gender dysphoria in adolescents and adults ● Gender identity disorder in adolescence and adulthood ● Gender incongruence in adolescents and adults ● Transgender
F64.1	Dual role transvestism
F64.8	Other gender identity disorders ● Other specified gender dysphoria
F64.9	Gender identity disorder, unspecified ● Gender dysphoria, unspecified ● Gender incongruence, unspecified ● Gender-role disorder NOS
Z31.62	Encounter for fertility preservation counseling
Z87.890	Personal history of sex reassignment

Table 3	
ICD-10 codes <u>not considered medically necessary</u> with Table 1 codes:	
Code	*Description*
F52.0 - F52.9	Sexual dysfunction not due to a substance or known physiological condition
F64.2	Gender identity disorder of childhood ● Gender dysphoria in children ● Gender incongruence of childhood
Q56.0 - Q56.4	Indeterminate sex and pseudohermaphroditism

Table 3	
ICD-10 codes not considered medically necessary with Table 1 codes:	
Code	*Description*
Q90.0 - Q99.9	Chromosomal anomalies, not elsewhere classified
R37	Sexual dysfunction, unspecified

Table 4	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal

Table 4	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity

Table 4	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes • Due to the broad nature of this code, clarification is provided below: • When billed for hair removal indicated for genital reconstruction, it is considered medically necessary. When billed for any other body part, it is considered NOT medically necessary.
19316	Mastopexy
21087	Impression and custom preparation; nasal prosthesis
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
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)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
27299	Unlisted procedure, pelvis or hip joint • Due to the broad nature of this code, clarification is provided below:

Table 4	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
	• When billed for gluteal augmentation, it is considered NOT medically necessary
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
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	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30999	Unlisted procedure, nose • Due to the broad nature of this code, clarification is provided below: • When billed for nose implants or facial feminization, it is considered NOT medically necessary
31599	Unlisted procedure, larynx • Due to the broad nature of this code, clarification is provided below: • When billed for thyroid chondroplasty / chondrolaryngoplasty, or voice modification surgery, it is considered NOT medically necessary
31750	Tracheoplasty; cervical
31899	Unlisted procedure, trachea, bronchi • Due to the broad nature of this code, clarification is provided below: • When billed for thyroid chondroplasty or chondrolaryngoplasty, it is considered NOT medically necessary
40650	Repair lip, full thickness; vermilion only
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
J0585	Injection, onabotulinumtoxinA, 1 unit

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Clinical Guideline Revision / History Information

Original Date: 8/1/2017
Reviewed/Revised: 1/18/2018, 7/31/2018, 7/23/2019, 7/21/2020, 12/31/2020, 9/1/2021, 12/1/2021, 1/26/2022, 4/25/2022, 01/31/2023, 05/02/2023, 07/19/2023, 01/23/2024, 11/01/2025, 08/01/2026, 09/01/2026