Oscar Clinical Guideline: Sex Reassignment Surgery (Gender Affirmation Surgery) and Non-Surgical Services (CG017, Ver. 15)

Sex Reassignment Surgery (Gender Affirmation Surgery) and Non-Surgical 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 mental health condition characterized by clinically significant distress when one's gender identity is contrary to the sex which was assigned at birth. The Plan follows guideline standards laid out by the World Professional Association for Transgender Health (WPATH) to determine the appropriate medical necessity criteria and support we can provide for our members. Therefore, the Plan considers sex reassignment surgery (gender affirmation surgery) medically necessary for members with documented gender dysphoria who meet the criteria laid out 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 affirmation services, please refer to the Plan's Oscar Clinical Guidelines: Diagnosis and Treatment of Infertility (CG016). Please check 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 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 Identity Disorder" is better known as "Gender Dysphoria" ("transexualism" or "transgenderism"), which typically refers to a difference between the gender identity and the assigned sex. This diagnosis can also be used when a person has a strong and persistent cross-gender identification (not concurrent with a physical intersex condition or simply a desire for any perceived cultural advantages of the other sex), marked by persistent discomfort with one's sex, or a sense of inappropriateness in the gender role of that sex, and causing clinically significant distress or impairment in social, occupational or other important areas of functioning. Gender Identity Disorder was a diagnostic classification in DSM-4-TR, which has been replaced by Gender Dysphoria in DSM-5-TR.

"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)" - this 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 include, but 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. The member has capacity to grant fully informed consent for treatment and associated risks; *and*
2. The member has persistent, well-documented gender dysphoria per DSM-5-TR Criteria for Gender Dysphoria in Adults and Adolescents, defined as meeting both of the following:
    a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least TWO of the following:
        i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics); *or*
        ii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics); *or*
        iii. A strong desire for the primary and/or secondary sex characteristics of the other gender; *or*
        iv. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender); *or*
        v. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender); *or*
        vi. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender); *and*
    b. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning; *and*

3. The 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, as defined by:
    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; *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 incongruence have been excluded; *and*
6. For adolescents, the member must have additional assessments to meet criteria:
    a. A comprehensive biopsychosocial assessment should be completed with mental and/or medical professionals as part of a multidisciplinary team; *and*
    b. The 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*
    c. The member has realistic expectations regarding the possibilities and limitations of surgery and a full understanding of the long-term consequences of surgical procedures; *and*
    d. The member has been evaluated for safety and the member 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 and Hysterectomy

Adults

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

1. General Medical Necessity Criteria for gender-affirming services 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. The 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. The member will be managed by a multidisciplinary team, risks and benefits discussed prior to surgery, understands aftercare requirements and follow-up assessments post-surgery.

Adolescents (For California and New York State Lines of Business Only)
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 gonadectomy, hysterectomy, or salpingo-oophorectomy. The 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. Reproductive options or fertility preservation have been discussed prior to these surgeries. The member must also meet criteria #6 under General Medical Necessity Criteria.

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 clinical criteria are met:

1. General Medical Necessity Criteria for gender-affirming services 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. The 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. The member will be managed by a multidisciplinary team, risks and benefits discussed prior to surgery, and follow-up assessments post-surgery.

Adolescents (For California and New York State Lines of Business Only)
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 genital reconstruction. The 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. Reproductive options or fertility preservation have been discussed prior to these surgeries. The member must also meet criteria #6 under General Medical Necessity Criteria.

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 clinical criteria are met:

1. General Medical Necessity Criteria for gender-affirming services 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. The 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 procedures. The 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. The member must also meet criteria #6 under General Medical Necessity Criteria.

Revision Surgery

Adults

Requests for revision surgery must be submitted with medical records demonstrating objective examination. Revision surgery may be considered medically necessary for ONE of the following:

1. To treat complications resulting from the initial surgery; *or*
2. To correct dysfunction resulting from the initial surgery; *or*
3. 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. The member must also meet criteria #6 under General Medical Necessity Criteria.

Non-Surgical Services (For New York State Lines of Business: See Appendix A; For California State Lines of Business: See Appendix B)

Non-surgical services are considered medically necessary when the General Medical Necessity Criteria are met; services include:

1. Psychotherapy to support the member through his/her gender transition
2. Vocal training with a speech language pathologist
3. Laboratory testing to monitor the safety and effectiveness of continuous hormone replacement therapy and/or puberty-suppressing hormone therapy
4. Breast cancer screening for female to male trans-identified individuals who have not undergone a mastectomy
5. Prostate cancer screening for male to female trans-identified individuals who have retained their prostate
6. 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 before and/or after gender affirmation surgery to be medically necessary when the following criteria are met:

1. Hormone replacement therapy in adults (age of majority) who are transitioning for the member's gender congruence goals when all of the following criteria are met:
    a. The requested medication has been prescribed by a qualified healthcare professional for persistent, well-documented gender dysphoria; *and*
    b. The member has capacity to grant fully informed consent for treatment and associated risks; *and*
    c. If significant medical or mental health concerns are present, the member must be receiving appropriate treatment and the condition must be reasonably well controlled; *and*
    d. Health care professionals must inform and counsel all individuals seeking gender-affirming medical treatment about the options available for fertility preservation prior to initiating puberty suppression and prior to treating with hormone therapy.
2. Puberty-suppressing hormone therapy in adolescents for the member's gender congruence goals or gender nonconformity when ALL of the following criteria are met:
    a. The requested medication has been prescribed by a qualified healthcare professional for a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed); *and*
    b. The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated; *and*
    c. If any significant medical, behavioral health, or social concerns are present that may interfere with treatment or adherence, the member must be receiving appropriate

treatment and the condition must be reasonably well controlled to start hormone therapy; *and*

d. The adolescent has given informed consent and, particularly 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; *and*
e. Health care professionals must inform and counsel all individuals seeking gender-affirming medical treatment about the options available for fertility preservation prior to initiating puberty suppression and prior to treating with hormone therapy.

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 Clinical Guideline: Sex Reassignment Surgery (Gender Affirmation Surgery) and Non-Surgical Services for Authorization or requirements, the policy's criteria will not apply.

Applicable to New York State Lines of Business: For the following sections, see Appendix A:

- Aesthetic or Other Non-chest/Genital Surgery
- Non-Surgical Services
- Experimental or Investigational / Not Medically Necessary
- Applicable Billing Codes

Applicable to California State Lines of Business: For the following sections, see Appendix B:

- Aesthetic or Other Non-chest/Genital Surgery
- Non-Surgical Services
- Experimental or Investigational / Not Medically Necessary
- Applicable Billing Codes

Experimental or Investigational / Not Medically Necessary (For New York State Lines of Business: See Appendix A; For California State Lines of Business: See Appendix B)

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 (For New York State Lines of Business: See Appendix A; For California State Lines of Business: See Appendix B)

Table 1	
Gender-Affirming Surgery	
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
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 and lack of specificity in certain scenarios, clarification is provided below: • When this code is billed for genital reconstruction, then 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 and lack of specificity in certain scenarios, clarification is provided below: • When this code is billed for genital reconstruction, then it is considered medically necessary

Table 1	
Gender-Affirming Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
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 and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for genital reconstruction, then 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 and lack of specificity in certain scenarios, clarification is provided below: ● When this code is 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 this code is billed for hair removal indicated for genital reconstruction, it is considered medically necessary. When this code is billed for any other body part, it is considered NOT medically necessary.

Table 1	
Gender-Affirming Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19318	Breast Reduction
19325	Breast augmentation with implant
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)

Table 1	
Gender-Affirming Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
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

Table 1	
Gender-Affirming Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
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

Table 1	
Gender-Affirming Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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)
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

Table 1	
Gender-Affirming Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
84153	Prostate specific antigen (PSA); 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

Table 1	
Gender-Affirming Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
C2622	Prosthesis, penile, non-inflatable
J1071	Injection, testosterone cypionate, 1 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 Surgery	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
L8600	Implantable breast prosthesis, silicone or equal
S0189	Testosterone pellet, 75 mg

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
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Table 3	
ICD-10 codes not considered medically necessary 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
Q56.0 - Q56.4	Indeterminate sex and pseudohermaphroditism
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
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid

Table 4	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
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
15858	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
15879	Suction assisted lipectomy; lower extremity
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:

Table 4	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
	• When this code is billed for hair removal indicated for genital reconstruction, it is considered medically necessary. When this code is 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 and lack of specificity in certain scenarios, clarification is provided below: • When this code is billed for gluteal augmentation, it is considered NOT medically necessary

Table 4	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
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 and lack of specificity in certain scenarios, clarification is provided below: ● When this code is 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 and lack of specificity in certain scenarios, clarification is provided below: ● When this code is 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 and lack of specificity in certain scenarios, clarification is provided below: ● When this code is 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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Appendix A - Applicable to New York State Lines of Business

Clinical Indications for the Eunuch Member

For the member who is a eunuch in the State of New York, who is assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning, the following criteria apply:

1. The clinical criteria starting from General Medical Necessity Criteria, Gonadectomy, Genital Reconstruction, to Revision Surgery apply; *and/or*
2. Aesthetic or Other Non-chest/Genital Surgery criteria apply; *and/or*
3. Non-surgical Services criteria apply; *and/or*
4. Continuous Hormone Therapy criteria apply.

Aesthetic or Other Non-chest/Genital Surgery & Non-surgical Services

Aesthetic or Other Non-chest/Genital Surgery

The following procedures/surgeries for the treatment of gender dysphoria is/are considered medically necessary when the procedure-specific clinical criteria are met (when applicable):

1. General Medical Necessity Criteria for gender-affirming services are met; *and*
2. Age of majority (18 years or older) or adolescents; *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. 1 year of full-time, continuous living in a gender role that conforms to the member's gender identity; *and*
5. Medical records support that the the requested procedure is intended to treat the underlying gender dysphoria by correcting a feature discongruent with the member's gender identity; *and*
6. Medical records support that the request procedure is not purely cosmetic in nature (i.e., solely to enhance appearance); *and*
7. For body contouring:
    a. The existing body contour is such that it causes significant well-documented distress directly related to the member's gender dysphoria; *or*
    b. The specific requested procedure is directly expected to improve this distress; *and*
    c. The requested service is one of the below:
        i. Mastectomy and/or creation of a male chest (with or without body contouring) for transmasculine or gender diverse members; *or*
        ii. Breast augmentation (with or without body contouring) for transfeminine members; *or*
        iii. Lipofilling, liposuction for breast/chest; *or*

iv. Gluteal or pectoral implants on a case-by-case basis; *and*

8. For facial feminization or facial masculinization:
    a. The existing facial feature is such that it causes significant well-documented distress directly related to the member's gender dysphoria; *and*
    b. The specific requested procedure is directly expected to improve this distress; *and*
    c. The requested service is one of the below:
        i. Blepharoplasty; *or*
        ii. Brow lift; *or*
        iii. Cheek augmentation; *or*
        iv. Forehead contouring; *or*
        v. Scalp advancement (only as needed in conjunction with forehead contouring); *or*
        vi. Rhinoplasty; *or*
        vii. Face lift or liposuction (only as needed in conjunction with one of the above procedures); *or*
        viii. Neck lift (only if the excess skin impairs the outcome of the covered facial feminization or masculinization procedures); *or*
        ix. Mandible reconstruction; *and*
9. For thyroid chondroplasty / chondrolaryngoplasty or cartilage reduction (commonly referred to as "tracheal shave" of the Adam's apple), the member is undergoing male-to-female transition.
10. For voice modification surgery (e.g., laryngoplasty):
    a. The member has tried 1 year of vocal training with a speech language pathologist; *and*
    b. ONE of the following:
        i. The member is undergoing male-to-female transition; *or*
        ii. The member is undergoing female-to-male transition and 2 years of consistent hormone use has not adequately addressed the vocal quality or is otherwise contraindicated.

Non-Surgical Services

Non-surgical services are considered medically necessary when General Medical Necessity Criteria are met, services include:

1. Psychotherapy to support the member through his/her gender transition
2. Vocal training with a speech language pathologist
3. Hair reconstruction (i.e., hair transplantation, hair removal/electrolysis) by a licensed and/or certified provider
4. Laboratory testing to monitor the safety and effectiveness of continuous hormone replacement therapy
5. Breast cancer screening for female to male trans-identified individuals who have not undergone a mastectomy
6. Prostate cancer screening for male to female trans-identified individuals who have retained their prostate

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 before and/or after gender affirmation surgery to be medically necessary when the following criteria are met:

1. Hormone replacement therapy in adults (age of majority) who are transitioning for the member's gender congruence goals when all of the following criteria are met:
    a. The requested medication has been prescribed by a qualified healthcare professional for persistent, well-documented gender dysphoria; *and*
    b. The member has capacity to grant fully informed consent for treatment and associated risks; *and*
    c. If significant medical or mental health concerns are present, the member must be receiving appropriate treatment and the condition must be reasonably well controlled; *and*
    d. Health care professionals must inform and counsel all individuals seeking gender-affirming medical treatment about the options available for fertility preservation prior to initiating puberty suppression and prior to treating with hormone therapy.
2. Puberty-suppressing hormone therapy in adolescents for the member's gender congruence goals or gender nonconformity when ALL of the following criteria are met:
    a. The requested medication has been prescribed by a qualified healthcare professional for a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed); *and*
    b. The adolescent's gender dysphoria emerged or worsened with the onset of puberty; *and*
    c. The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated; *and*
    d. If any significant medical, behavioral health, or social concerns are present that may interfere with treatment or adherence, the member must be receiving appropriate treatment and the condition must be reasonably well controlled to start hormone therapy; *and*
    e. The adolescent has given informed consent and, particularly 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; *and*
    f. Health care professionals must inform and counsel all individuals seeking gender-affirming medical treatment about the options available for fertility preservation prior to initiating puberty suppression and prior to treating with hormone therapy.

Experimental or Investigational / 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 by the Plan.

Elective Reversal of Gender Affirmation Surgery

Gender-affirming surgery requires a team of providers and specialists to work with a patient in order to decide whether it is the most appropriate treatment approach and intervention. It requires specific criteria be met, over a period of time to ensure the surgery will meet the specific needs of the patient and have minimal medical and psychological risks. The results of sex reassignment surgery are difficult to reverse, as some of the procedures are irreversible (Djordjevic, 2016). There has been limited research to examine the variables that correlate with worsened biological, psychological, or social conditions following transition and occurrence is rare (Hall et al., 2021; Littman, 2021).

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. Therefore, the following services are considered not medically necessary, and include but not limited to the following:

1. Abdominoplasty
2. Botulinum toxin injections
3. Calf implants
4. Mastopexy
5. Panniculectomy
6. Skin resurfacing or removal of redundant skin, except when a direct result of a medically necessary surgery
7. Speech therapy not provided by a speech language pathologist, as it is considered experimental or investigational
8. Speech therapy performed in a group setting, as it is considered experimental or investigational
9. 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

Applicable Billing Codes

Table 5	
Gender Affirmation 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
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
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
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
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
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)

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk [medically necessary when used for genital reconstruction only]
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel [medically necessary when used for genital reconstruction only]
15750	Flap; neurovascular pedicle [medically necessary when used for genital reconstruction only]
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate [For breast/chest procedures]
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) [For breast/chest procedures]
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15819	Cervicoplasty
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
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15858	Rhytidectomy; cheek, chin, and neck
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19318	Reduction mammaplasty
19325	Breast augmentation with implant
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)
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

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
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
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 and lack of specificity in certain scenarios, clarification is provided below: • When this code is billed for gluteal augmentation, it is considered medically necessary on a case by case basis
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)

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30999	Unlisted procedure, nose ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for gender affirmation services, it must meet the criteria above in Appendix A to meet medical necessity
31599	Unlisted procedure, larynx ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for gender affirmation services, it must meet the criteria above in Appendix A to meet medical necessity such as thyroid chondroplasty / chondrolaryngoplasty, or voice modification surgery
31750	Tracheoplasty; cervical
31899	Unlisted procedure, trachea, bronchi ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for gender affirmation services, it must meet the criteria above in Appendix A to meet medical necessity such as thyroid chondroplasty / chondrolaryngoplasty
40650	Repair lip, full thickness; vermilion only
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
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

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
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

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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 (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

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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)
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)

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
84153	Prostate specific antigen (PSA); 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

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
J1071	Injection, testosterone cypionate, 1 mg
J1380	Injection, eEstradiol Valerate 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

Table 5	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
L8600	Implantable breast prosthesis, silicone or equal
S0189	Testosterone pellet, 75 mg

Table 6	
ICD-10 codes considered medically necessary with Table 5 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
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Table 7	
ICD-10 codes <u>not considered medically necessary</u> with Table 5 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
Q56.0 - Q56.4	Indeterminate sex and pseudohermaphroditism

Table 7	
ICD-10 codes not considered medically necessary with Table 5 codes:	
Code	*Description*
Q90.0 - Q99.9	Chromosomal anomalies, not elsewhere classified
R37	Sexual dysfunction, unspecified

Table 8	
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)
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
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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

Table 8	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
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)
19316	Mastopexy
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
J0585	Injection, onabotulinumtoxinA, 1 unit

Appendix B - Applicable to California State Lines of Business

Clinical Indications for the Eunuch Member

For the member who is a eunuch in the State of California, who is assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning, the following criteria apply:

1. The clinical criteria starting from General Medical Necessity Criteria, Gonadectomy, Genital Reconstruction, to Revision Surgery apply; *and/or*
2. Aesthetic or Other Non-chest/Genital Surgery criteria apply; *and/or*
3. Non-surgical Services criteria apply; *and/or*
4. Continuous Hormone Therapy criteria apply.

Aesthetic or Other Non-chest/Genital Surgery & Non-surgical Services

Aesthetic or Other Non-chest/Genital Surgery

The following procedures/surgeries for the treatment of gender dysphoria is/are considered medically necessary when the procedure-specific clinical criteria are met (when applicable):

1. General Medical Necessity Criteria for gender-affirming services are met; *and*
2. Age of majority (18 years or older) or adolescents; *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. 1 year of full-time, continuous living in a gender role that conforms to the member's gender identity; *and*
5. Medical records support that the the requested procedure is intended to treat the underlying gender dysphoria by correcting a feature discongruent with the member's gender identity
6. Medical records support that the request procedure is not purely cosmetic in nature (i.e., solely to enhance appearance); *and*
7. For body contouring:
    a. The existing body contour is such that it causes significant well-documented distress directly related to the member's gender dysphoria; *or*
    b. The specific requested procedure is directly expected to improve this distress; *and*
    c. The requested service is one of the below:
        i. Mastectomy and/or creation of a male chest (with or without body contouring) for transmasculine or gender diverse members; *or*
        ii. Breast augmentation (with or without body contouring) for transfeminine members; *or*
        iii. Lipofilling, liposuction for breast/chest; *or*
        iv. Gluteal or pectoral implants on a case-by-case basis; *and*
8. For facial feminization or facial masculinization:

a. The existing facial feature is such that it causes significant well-documented distress directly related to the member's gender dysphoria; *and*
b. The specific requested procedure is directly expected to improve this distress; *and*
c. The requested service is one of the below:
    i. Blepharoplasty; *or*
    ii. Brow lift; *or*
    iii. Cheek augmentation; *or*
    iv. Forehead contouring; *or*
    v. Scalp advancement (only as needed in conjunction with forehead contouring); *or*
    vi. Rhinoplasty; *or*
    vii. Face lift or liposuction (only as needed in conjunction with one of the above procedures); *or*
    viii. Neck lift (only if the excess skin impairs the outcome of the covered facial feminization or masculinization procedures); *or*
    ix. Mandible reconstruction; *and*

9. For thyroid chondroplasty / chondrolaryngoplasty or cartilage reduction (commonly referred to as "tracheal shave" of the Adam's apple), the member is undergoing male-to-female transition.
10. For voice modification surgery (e.g., laryngoplasty):
    a. The member has tried 1 year of vocal training with a speech language pathologist; *and*
    b. ONE of the following:
        i. The member is undergoing male-to-female transition; *or*
        ii. The member is undergoing female-to-male transition and 2 years of consistent hormone use has not adequately addressed the vocal quality or is otherwise contraindicated.

Non-Surgical Services

Non-surgical services are considered medically necessary when the General Medical Necessity Criteria are met; services include:

1. Psychotherapy to support the member through his/her gender transition
2. Vocal training with a speech language pathologist
3. Hair reconstruction (i.e., hair transplantation, hair removal/electrolysis) performed by a licensed and/or certified provider
4. Laboratory testing to monitor the safety and effectiveness of continuous hormone replacement therapy
5. Breast cancer screening for female to male trans-identified individuals who have not undergone a mastectomy
6. Prostate cancer screening for male to female trans-identified individuals who have retained their prostate

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 before and/or after gender affirmation surgery to be medically necessary when the following criteria are met:

1. Hormone replacement therapy in adults (age of majority) who are transitioning for the member's gender congruence goals when all of the following criteria are met:
    a. The requested medication has been prescribed by a qualified healthcare professional for persistent, well-documented gender dysphoria; *and*
    b. The member has capacity to grant fully informed consent for treatment and associated risks; *and*
    c. If significant medical or mental health concerns are present, the member must be receiving appropriate treatment and the condition must be reasonably well controlled; *and*
    d. Health care professionals must inform and counsel all individuals seeking gender-affirming medical treatment about the options available for fertility preservation prior to initiating puberty suppression and prior to treating with hormone therapy.
2. Puberty-suppressing hormone therapy in adolescents for the member's gender congruence goals or gender nonconformity when ALL of the following criteria are met:
    a. The requested medication has been prescribed by a qualified healthcare professional for a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed); *and*
    b. The adolescent's gender dysphoria emerged or worsened with the onset of puberty; *and*
    c. The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated; *and*
    d. If any significant medical, behavioral health, or social concerns are present that may interfere with treatment or adherence, the member must be receiving appropriate treatment and the condition must be reasonably well controlled to start hormone therapy; *and*
    e. The adolescent has given informed consent and, particularly 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; *and*
    f. Health care professionals must inform and counsel all individuals seeking gender-affirming medical treatment about the options available for fertility preservation prior to initiating puberty suppression and prior to treating with hormone therapy.

Experimental or Investigational / 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 by the Plan.

Elective Reversal of Sex Reassignment Surgery

Sex reassignment surgery requires a team of providers and specialists to work with a patient in order to decide whether it is the most appropriate treatment approach and intervention. It requires specific criteria be met, over a period of time to ensure the surgery will meet the specific needs of the patient and have minimal medical and psychological risks. The results of sex reassignment surgery are difficult to reverse, as some of the procedures are irreversible (Djordjevic, 2016). There has been limited research to examine the variables that correlate with worsened biological, psychological, or social conditions following transition and occurrence is rare (Hall et al., 2021; Littman, 2021).

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. Therefore, the following services are considered not medically necessary and include, but not limited to the following:

1. Abdominoplasty
2. Botulinum toxin injections
3. Calf implants
4. Mastopexy
5. Panniculectomy
6. Skin resurfacing or removal of redundant skin, except when a direct result of a covered surgery
7. Speech therapy not provided by a speech language pathologist, as it is considered experimental or investigational
8. Speech therapy performed in a group setting, as it is considered experimental or investigational
9. 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

Applicable Billing Codes

Table 9	
Gender Affirmation 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
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
11970	Replacement of tissue expander with permanent implant

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
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 [medically necessary when used for genital reconstruction only]
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
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
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)

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk [medically necessary when used for genital reconstruction only]
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel [medically necessary when used for genital reconstruction only]
15750	Flap; neurovascular pedicle [medically necessary when used for genital reconstruction only]
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate [For breast/chest procedures]
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) [For breast/chest procedures]
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15819	Cervicoplasty
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
15858	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19318	Reduction mammaplasty
19325	Breast augmentation with implant
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)
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

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
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
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 and lack of specificity in certain scenarios, clarification is provided below: • When this code is billed for gluteal augmentation, it is considered medically necessary on a case by case basis
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)

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30999	Unlisted procedure, nose ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for gender affirmation services, it must meet the criteria above in Appendix B to meet medical necessity
31599	Unlisted procedure, larynx ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for gender affirmation services, it must meet the criteria above in Appendix B to meet medical necessity such as thyroid chondroplasty / chondrolaryngoplasty, or voice modification surgery
31750	Tracheoplasty; cervical
31899	Unlisted procedure, trachea, bronchi ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for gender affirmation services, it must meet the criteria above in Appendix B to meet medical necessity such as thyroid chondroplasty / chondrolaryngoplasty
40650	Repair lip, full thickness; vermilion only
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
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

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
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

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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 (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

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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)
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)

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
84153	Prostate specific antigen (PSA); 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

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
J1071	Injection, testosterone cypionate, 1 mg
J1380	Injection, estradiol valerate 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

Table 9	
Gender Affirmation Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
L8600	Implantable breast prosthesis, silicone or equal
S0189	Testosterone pellet, 75 mg

Table 10	
ICD-10 codes considered medically necessary with Table 9 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
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Table 11	
ICD-10 codes <u>not considered medically necessary</u> with Table 9 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
Q56.0 - Q56.4	Indeterminate sex and pseudohermaphroditism

Q90.0 - Q99.9	Chromosomal anomalies, not elsewhere classified
R37	Sexual dysfunction, unspecified

Table 12	
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)
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
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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)

Table 12	
CPT/HCPCS codes not considered medically necessary for indications listed in this guideline:	
Code	*Description*
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
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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)
19316	Mastopexy
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
J0585	Injection, onabotulinumtoxinA, 1 unit