Clinical Policy: Gender Affirming Procedures

Reference Number: CA.CP.MP.496
Effective Date: 11/09
Last Review Date: 2/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Services for gender affirmation most often include hormone treatment, counseling, psychotherapy, complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate, genital reconstruction, facial hair removal, and certain facial plastic reconstruction. Not every individual will require each intervention, so necessity needs to be considered on an individualized basis. This criteria outlines medical necessity criteria for gender-affirming medical and surgical treatment (GAMST) *when such services are included under the member/enrollee's benefit plan contract provisions.*

*Note: For procedures related to fertility preservation please see policy *CP.MP.130 Fertility Preservation.*

For Medi-Cal Members, please refer to the medi-cal manual and the "State of California Health and Human Services Agency Department of Health Care Services All Plan Letters (APL) 20-018 Ensuring Access to Transgender Services October 26, 2020"

Policy/Criteria

I. It is the policy of California Health & Wellness that gender-affirming surgeries are considered **medically necessary** for members/enrollees when diagnosed with gender dysphoria or gender incongruence per section A. and when meeting the eligibility criteria in section B.

Note: Intersex individuals are not subject to the criteria in this policy.

A. Gender Dysphoria or Gender Incongruence Criteria
   1. Marked and sustained incongruence between the member/enrollee's experienced/expressed gender and assigned gender, as *indicated by two or more* of the following:
      a. Marked incongruence between the member/enrollee's experienced/expressed gender and primary and/or secondary sex characteristics;
      b. 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;
      c. A strong desire for the primary and/or secondary sex characteristics of the other gender;
      d. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);
      e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender);

f. 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);
g. The condition is associated with impairment in social, occupational, or other important areas of functioning.

B. Eligibility criteria, all of the following:
1. Capacity to make a fully informed decision (including, but not limited to, awareness of the potential effects of treatment on fertility) and to consent for treatment;
2. If significant medical or mental health concerns present, they are reasonably well controlled;
3. Other possible causes of apparent gender dysphoria, gender incongruence, or gender diversity have been identified and excluded;
4. Minimum of one written statement with signature recommending gender-affirming medical and surgical treatment (GAMST) from a health care provider competent to independently assess and diagnose gender incongruence;
5. One of the following:
   a. For members ≥ 18 years, all of the following:
      i. Assessment for GAMST from a provider who meets both of the following:
         a) Has experience in or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider);
         b) Is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated;
      ii. The documented assessment for GAMST meets all of the following:
         a) Identifies any mental or physical health conditions that could negatively impact the outcome of GAMST, with risks and benefits discussed;
         b) Notes the member/enrollee's capacity to understand the effect of GAMST on reproduction and includes a discussion of reproductive options with the member/enrollee prior to the initiation of GAMST;
      iii. Member/enrollee remains stable on their gender affirming hormonal treatment regime which may include at least six months of hormone treatment or longer if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).
   b. For members/enrollees < 18 years all of the following:
      i. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
      ii. Has reached Tanner stage 2;
      iii. Member/enrollee has been informed of the reproductive effects of GAMST, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development;

iv. Member/enrollee has completed a minimum of 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated;
v. Assessment for GAMST from a provider who meets both of the following:
a) Has experience in or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider);
b) Is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated;

C. Gender-affirming surgeries considered medically necessary when meeting above criteria and additional criteria as listed below for specific procedures:
1. For members/enrollees age < 18 years, any of the following:
a. One of the following procedures is requested:
i. Penectomy;
ii. Urethroplasty;
iii. Mammoplasty;
iv. Mastectomy, and the member/enrollee has been assessed for risk factors associated with breast cancer;
v. Clitoroplasty;
vi. Vulvoplasty;
vii. Labiaplasty;
viii. Vaginectomy;
ix. Vulvectomy;
x. Scrotoplasty;
xi. Testicular prosthesis;
b. Twelve months of hormone therapy has been administered (unless hormone therapy is not desired or is medically contraindicated) and one of the following procedures has been requested:
i. Breast augmentation, and the member/enrollee has been assessed for risk factors associated with breast cancer;
ii. Phalloplasty;
iii. Metoidioplasty;
iv. Vaginoplasty;
v. Gonadectomy (i.e., hysterectomy, orchiectomy);
2. For members/enrollees ≥ 18 years of age, any of the following:
a. Penectomy;
b. Urethroplasty;
c. Mammoplasty;

d. Mastectomy, and the member/enrollee has been assessed for risk factors associated with breast cancer;
e. Clitoroplasty;
f. Vulvoplasty;
g. Labiaplasty;
h. Vaginectomy;
i. Vulvectomy;
j. Scrotoplasty;
k. Testicular prosthesis;
l. Breast augmentation, and the member/enrollee has been assessed for risk factors associated with breast cancer;
m. Phalloplasty;
n. Metoidioplasty;
o. Vaginoplasty;
p. Gonadectomy (i.e., hysterectomy, salpingo-oophorectomy, orchiectomy; at least six months of hormone therapy may be considered prior to procedure, as appropriate for the member/enrollee's goals).

II. It is the policy of California Health & Wellness that gender affirming facial procedures will be considered for medical necessity on a case-by-case basis when meeting the following:
A. Criteria has been met in section I.A. and I.B.;
B. Requested procedure intends to correct existing facial appearance that demonstrates significant variation from standard appearance for the experienced gender. For members/enrollees <18 years, 12 months of hormone therapy is required prior to facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or medically contraindicated. Possible procedures include, but are not limited to, the following:
1. Blepharoplasty;
2. Face lift/mid-face lift/brow lift;
3. Facial implants and bone reconstruction;
4. Hair removal/electrolysis
5. Drugs for hair loss or growth;
6. Hair transplantation or hairline advancement;
7. Prosthetic or filler substances to alter contour;
8. Rhinoplasty;
9. Thyroid chondroplasty;
10. Removal of redundant skin;
11. Upper lip shortening and lip augmentation;
12. Chondrolaryngoplasty;
13. Voice modification surgery, therapy, or lessons. It is the policy of Health Net of California to consider voice modification surgery (such as laryngoplasty or shortening of the vocal cords) related to transgender dysphoria, aaccording to the following:

a. Voice deepening surgery (eg thyroplasty) is considered medically necessary if the voice fails to deepen after 2 years of consistent masculinization hormone therapy.
b. Voice feminization surgery (cricothyroid approximation or CTA) is considered medically necessary when the following are met:
    i. Documentation demonstrating the member has been diagnosed with transgenderism (as defined by WPATH) by qualified professionals;
    ii. Documentation that voice therapy has been provided and proven ineffective as attested to by a qualified voice therapist (trans-sensitive speech-language therapists using standard voice and communication protocols);
    iii. Documentation of completed pre-operative assessments by both a laryngologist and speech-language therapist who agreed to the clinical benefits in achieving transitional goals;
    iv. Documentation that a qualified voice and communication specialist (who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists) will follow the patient post-operatively to maximize the surgical outcome.

III. It is the policy of California Health & Wellness that revision procedures for affirming gender are **medically necessary** when the revision is required to address complications of a prior gender affirming procedure (wound dehiscence, fistula, chronic pain directly related to the surgery, etc.).

IV. Medically Necessary Reconstructive Surgery
It is the policy of California Health & Wellness that each of the following procedures, when used specifically to improve the appearance of an individual undergoing gender reassignment surgery or actively participating in a documented gender reassignment surgery treatment plan, must be evaluated to determine if it is medically necessary reconstructive surgery to create a normal appearance for the gender with which the member identifies. Prior to making a clinical determination of coverage, it may be necessary to consult with a qualified and licensed mental health professional and the treating surgeon. This may not be an all inclusive list

A. Abdominoplasty
B. Liposuction
C. Skin resurfacing
D. Mastopexy
E. Revision procedures for purposes other than correction of complications.

V. It is the policy of California Health & Wellness that detransition procedures by gender-related hormone intervention, surgical intervention, or both, will be considered for medical necessity on a case-by-case basis.

Background

Gender identity is a person's deepest inner sense of being female or male, which for many is established by the age of two through three years. *Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.[5] *Gender dysphoria* refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).[2,5] Per WPATH, the focus of gender dysphoria is not on the individual's gender identity, but on any of the distress or discomfort related to being transgender and gender diverse (TGD).[10] WPATH states that gender incongruence is considered a condition with a focus on the TGD person's experienced identity and any need for gender-affirming treatment that arises from this identity.[10]

Treatment to assist people with gender dysphoria is available and can help to find the gender identity and role that is comfortable for them. Treatment is very individualized and may or may not involve gender-affirming surgery or body modification. Treatment options include changes in gender expression and role; hormone therapy to feminize or masculinize the body; surgery to change primary and/or secondary sex characteristics; and psychotherapy. Many people who receive treatment for gender dysphoria will find a gender role and expression that is comfortable for them, regardless of whether they differ from the sex assigned them at birth.

The World Professional Association for Transgender Health (WPATH) is an international professional society dedicated to promoting the highest level of evidence-based principles for transgender and gender diverse (TGD) individuals. WPATH's Standards of Care (SOC) are a series of flexible guidelines for clinical practice published by the society and are based on evidence and expert consensus.[20] Version 8 of WPATH's SOC were published in 2022, and these guidelines offer clinical guidance to health care professionals caring for TGD people and are intended to be adaptable to meet the diverse health care needs of this population.

WPATH recommends that the assessment for gender-affirming medical and surgical treatment (GAMST) in individuals < 18 years old be completed by a provider who is licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution. The provider(s) working with gender diverse adolescents should additionally meet all of the following[10]:

1. Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum;
2. Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span;
3. Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents;
4. Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families;

5. Complete a comprehensive biopsychosocial assessment of the adolescent member/enrollee presenting with gender identity-related concerns and seek medical/surgical transition-related care in a collaborative and supportive manner;
6. Maintain an ongoing relationship with the gender diverse and transgender adolescent member/enrollee and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender- related surgery until the transition is made to adult care;
7. Involve parent(s)/guardian(s) in the GAMST assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible;
8. Involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

WPATH recommends that the assessment for GAMST in adults ≥ 18 years of age be completed by a provider who is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider). The provider(s) working with gender diverse adults should additionally meet all of the following[10]:

1. Identify co-existing mental health or other psychosocial concerns, distinguishing these from gender dysphoria, incongruence, and diversity;
2. Assess capacity to consent for treatment (capacity to consent is required for GAMST assessment);
3. Have experience or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity and is able to liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required;
4. Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments;
5. Ensure any mental or physical health conditions that could negatively impact the outcome of GAMSTs are assessed, with risks and benefits discussed, before a decision is made regarding treatment;
6. Assess the member/enrollee's capacity to understand the effect of GAMST on reproduction and discuss reproduction options with the member/enrollee prior to the initiation of GAMST;
7. Assess and discuss the role of social transition with the member/enrollee requesting GAMST.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes that may be considered part of gender-affirming surgery.
This code list does not indicate if a procedure is or is not considered medically necessary.

CPT® Codes	Description
11950 through 11954	Subcutaneous injection of filling material (eg, collagen)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent 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
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, 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
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15600	Delay of flap or sectioning of flap (division and inset); at trunk
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780 through 15783	Dermabrasion

CPT® Codes	Description
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
15820 through 15823	Blepharoplasty
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832 through 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876 through 15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
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)
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
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

CPT® Codes	Description
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)
31599	Unlisted procedure, larynx
31580	Laryngoplasty; for laryngeal web, 2-stage, with keel insertion and removal
31587	Laryngoplasty, cricoid split
31899	Unlisted procedure, trachea, bronchi
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type)
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion
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 female urethra
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
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

CPT® Codes	Description
54520	Orchiectomy simple with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty 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 vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction artificial vagina; without graft
57292	Construction 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 intersex state
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 uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

CPT® Codes	Description
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
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
58999	Unlisted procedure, female genital system (nonobstetrical)
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed; specialist reviewed	11/14	11/14
Added clitoroplasty, vulvoplasty and labiaplasty to section III.A. References reviewed and updated. Codes reviewed and updated.	09/18	10/18

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Removed separate section on Hormone Therapy. Added section on voice modulation surgery (Health Net policy)	1/19	1/19
Replaced term "gender reassignment" with "gender affirmation" throughout the policy and changed title to "Gender Affirming Procedures". Added criteria for endometrial ablation as a medically necessary procedure for transmen. Added as not medically necessary brow lift and voice therapy/lessons. Codes reviewed (14040 corrected and 14001 and 15101 added, along with various description updates). Reviewed by specialist.	10/19	10/19
Corporate changes: Replaced term "gender reassignment" with "gender affirmation" throughout the policy and changed title to "Gender Affirming Procedures". Added criteria for endometrial ablation as a medically necessary procedure for transmen. Removed recommendation (in Section III) that male to female receive hormone therapy prior to breast augmentation. Reviewed by specialist	11/19	11/19
Removed indication for endometrial ablation as it is included in CP.MP.106.	11/19	11/19
Removed CPT code 19304 - code deleted 1/1/2020	04/20	
Added statement that revision procedures are medically necessary when performed to correct procedure complications. Added revisions for other purposes to the cosmetic, not medically necessary list. Removed background statement that only some transgender, transsexual, and gender nonconforming people experience gender dysphoria. References reviewed and updated.	08/20	08/20
Added reference to State of California—Health and Human Services Agency Department of Health Care Services All Plan Letters (APL) 20-018 Ensuring Access to Transgender Services October 26, 2020 (Health Net policy)	11/20	11/20
Added characteristics of a mental health provider to II.F and II.G. Revised criteria in II.G to allow second referral letter from a qualified mental health provider, rather than limiting to psychologist or psychiatrist. References reviewed and updated. Description of CPT 11970, 19325 revised in 2021. CPT 19324, 58293 deleted in 2021. Replaced "member" with "member/enrollee."	03/21	04/21
Revised and reformatted policy. Revised gender dysphoria diagnosis requirements based on DSM-V, replaced psychiatrist/psychologist with qualified behavioral health practitioner, added section of mental health providers for children and adolescents, revised letter requirement, removed requirement for 12 months in associated gender for chest surgery and reformatted surgical procedure requirements by type of surgery. Replaced 'electrolysis' with "hair removal' to indicate other acceptable methods. Added reference to CA legal opinion for chest	5/21	5/21

Reviews, Revisions, and Approvals	Revision Date	Approval Date
surgery. Description of CPT 11970, 19325 revised in 2021. CPT 19324, 58293 deleted in 2021 (Health Net policy)		
Added 19318 to the list of CPT codes that may be considered part of gender affirming procedures.	11/21	
Annual Review. Changed "Last Review Date" to "Date of Last Revision" in the header. Added note before the criteria section stating that individuals with a disorder of sexual development (i.e. intersex) don't need to meet all the same criteria for duration of gender dysphoria, age requirements and duration of prior treatment such as hormone therapy. Incorporated gender-neutral language to the eligibility and criteria section II. A. 1, E. and III. A. and B. In II.B., noted that informed consent includes awareness of treatment effects on fertility. Added the word "minimum" to degree requirement in criteria II.F. and G. In II.E, noted that the requirement of 12 months of hormone therapy before mastectomy in adolescents should be considered on a case-by-case basis. Added new criteria in section IV regarding facial procedures, and modified the not medically necessary procedures list in VI accordingly. Grammatical changes made to the background with no impact to the policy. "Date" changed to "Revision Date" in the revision log header. References reviewed and updated. Specialist reviewed.	08/22	08/22
Corporate policy:Criteria updated to incorporate WPATH Standards of Care version 8 (SOC-8). Noted that intersex individuals are not subject to this criteria I. Background updated to reflect updates in WPATH SOC-8. Reference list updated to replace WPATH SOC-7 to SOC-8. Reviewed by internal specialist and external specialist. Corporate policy is used as a basis for HN policy with modifications to reflect California mandates. Changes in new SOC8 include: 1. One letter from a qualified provider is required for genital surgery 2. For those > =18, 6 months of hormone therapy (unless not desired is contraindicated) is the minimum requirement prior to surgery (5.a.iii) 3. There is now a section for those under 18 (5.b and C.1) including criteria for surgery including facial procedures , 12 months hormone therapy unless not desired is contraindicated 4. Section I.C.2 for over 18, minimum of 6 months of hormone therapy (unless not desired is contraindicated) is noted and the requirement to live 12 months in the desired gender has been removed 5. Section II: gender affirming facial surgeries moved to this section 6. Section II.B.4., the elements under Hair Removal have been removed and to simply state "Hair removal/electrolysis"	01/23	02/23 Approved Implementation Date: June 2023

Reviews, Revisions, and Approvals	Revision Date	Approval Date
7. Section II.B.13, Voice Modification Surgery criteria has been moved here but no changes 8. Section III added to address when revision surgery is considered medically necessary 9. Section IV – Medically Necessary Reconstructive Surgery section moved here 10. Section V added to addresses detransitioning 11. Under Background, provider qualifications for < and >= 18 are more detailed than in the SOC7		

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013.
2. Fisk NM. Editorial: Gender dysphoria syndrome – the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *West J Med* 120:386 to 391, May 1974.
3. Hayes Medical Technology Directory. Sex reassignment surgery for the treatment of gender dysphoria. May 11, 2015. Annual Review July 27, 2021. Accessed July 18, 2022.
4. Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. 2011.
5. Knudson G, De Cuypere G, Bockting W. Recommendations for revision of the DSM diagnoses of gender identity disorders: Consensus statement of The World Professional Association for Transgender Health. *Int J Transgend*, 12(2);115 to 118.
6. Levine DA, Committee on Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics* 2013;132;e297. http://pediatrics.aappublications.org/content/132/1/e297
8. Safer JD, Tangpricha, V. Transgender men: Evaluation and management. UpToDate. www.uptodate.com. Published December 2, 2020. Accessed July 18, 2022.
9. The World Professional Association for Transgender Health, Inc. (WPATH). Position statement on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A. https://www.wpath.org/newsroom/medical-necessity-statement Published June 2008 (updated December 2016). Accessed July 18, 2022.
10. The World Professional Association for Transgender Health, Inc. (WPATH). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644. Published September 15, 2022. Accessed November 08, 2022.
11. American College of Obstetricians and Gynecologists. Health Care for Transgender and Gender Diverse Individuals. Committee opinion number 823 (replaces committee opinion 512 and 685. www.acog.org. Published March 2021. Accessed April 6. 2021.

12. van de Grift TC, Elaut E, Cerwenka SC, et al. Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study. *J Sex Marital Ther*. 2017 May 4:1 to 11.
13. Papadopulos NA, Lellé JD, Zavlin D, et al. Quality of Life and Patient Satisfaction Following Male-to-Female Sex Reassignment Surgery. *J Sex Med*. 2017 May;14(5):721 to 730.
14. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*, November 2017, 102(11):3869 to 3903.
15. Local Coverage Article Gender Reassignment Services for Gender Dysphoria (A53793). Centers for Medicare and Medicaid Services website https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Published Oct 1, 2015 (revised January 1, 2021). Accessed April 6, 2021.
16. Van Damme S, Cosyns M, Deman S, et al. The Effectiveness of Pitch-raising Surgery in Male-to-Female Transsexuals: A Systematic Review. *J Voice*. 2017 Mar;31(2):244.e1 to 244.e5. doi: 10.1016/j.jvoice.2016.04.002. Epub 2016 Jul 28.
17. Mahfouda S, Moore JK, Siafarikas A, et al. Gender-affirming Hormones and Surgery in Transgender Children and Adolescents. *Lancet Diabetes Endo*. 2019 Jun;7(6):484 to 498.
18. Butler RM., Horenstein A, Gitlin M, et al. (2019). Social anxiety among transgender and gender nonconforming individuals: The role of gender-affirming medical interventions. *J Abnorm Psychol, 128*(1), 25 to 31.
19. Ferrando C, Thomas TN. Gender-affirming surgery: Male to female. UpToDate. www.uptodate.com. Published October 04, 2022. Accessed November 22, 2022.
20. Ferrando C, Nikolavsky D, Zhao, LC. Gender Affirming surgery: female to male. UpToDate. www.uptodate.com. Published July 8, 2022. Accessed July 18, 2022.
21. State of California—Health and Human Services Agency Department of Health Care Services All Plan Letters (APL) 20-018 Ensuring Access to Transgender Services October 26, 2020
22. State of California -California Health & Safety Code 1367.63

Important Reminder

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

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollee. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.