Gender Reassignment Services for Gender Dysphoria
Corporate Medical Policy

File name: Gender Reassignment Services for Gender Dysphoria
File Code: UM.SURG.06
Origination: 5/30/2011
Last Review: 06/2016
Next Review: 06/2017
Effective Date: 09/01/2016

Description

GENDER DYSPHORIA (GD)

Gender Dysphoria (GD) is defined by the *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, Text Revision [DSM-5]* as a condition characterized by the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender also known as birth gender, which is the individual's sex determined at birth. The diagnosis may be made in children, adolescents and adults, and there are separate diagnostic criteria in DSM-5 for children, and adolescents/adults. Individuals with gender dysphoria experience confusion in their biological gender during their childhood, adolescence or adulthood. In order for the diagnosis to be made there must also be evidence of distress about this biological sex/gender incongruence. This significant distress requirement distinguishes this new nomenclature from the previous term, in DSM-IV, which was gender identity disorder. These individuals demonstrate clinically significant distress or impairment in social, occupational, or other important areas of functioning. GD is characterized by the desire to have the anatomy of the other sex, and the desire to be regarded by others as a member of the other sex. Individuals with GD may develop social isolation, emotional distress, poor self-image, depression and anxiety. The diagnosis of GD is not made if the individual has a congruent physical intersex condition such as congenital adrenal hyperplasia.

Transgender- Is a general descriptive term that refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their birth gender.

Transsexual- Denotes any individual who seeks, or has undergone, a social transition from male to female or female to male, which in some cases also involves a physical transition by feminizing/masculinizing hormone therapy and genital surgery (sex reassignment surgery).

GENDER REASSIGNMENT THERAPY
GD cannot be treated by psychotherapy or through medical intervention alone. Integrated therapeutic approaches are used to treat GD, including psychological interventions and gender reassignment therapy. Gender reassignment therapy, either

as male-to-female transsexuals (transwomen) or as female-to-male transsexuals (transmen), consists of medical and surgical treatment that changes primary or secondary sex characteristics. Initially, the individual may go through the real-life experience in the desired role, followed by cross-sex hormone therapy and gender reassignment surgery to change the genitalia and other sex characteristics. The difference between feminizing/masculinizing hormone therapy and gender reassignment surgery is that the surgery is considered an irreversible physical intervention.

Gender reassignment surgical procedures are not without risk for complications; therefore, individuals should undergo an extensive evaluation to explore psychological, family, and social issues prior to and post-surgery.

READINESS FOR THE TREATMENT OF GENDER DYSPHORIA

Readiness criteria for gender reassignment surgery includes the individual demonstrating progress in consolidating gender identity, and demonstrating progress in dealing with work, family, and interpersonal issues resulting in an improved state of mental health. In order to check the eligibility and readiness criteria for gender reassignment surgery, it is important for the individual to discuss the matter with a professional provider who is well-versed in the relevant medical and psychological aspects of GD. The mental health and medical professional providers responsible for the individual's treatment should work together in making a decision about the use of feminizing/masculinizing hormones during the months before the gender reassignment surgery. Transsexual individuals should regularly participate in psychotherapy in order to have smooth transitions and adjustments to the new social and physical outcomes.

TRANS-SPECIFIC CANCER SCREENINGS

Professional organizations such as the American Cancer Society, American College of Obstetricians and Gynecologists and the US Preventive Services Task Force provide recommended cancer screening guidelines to facilitate clinical decision-making by professional providers. Some cancer screening protocols are sex/gender specific based on assumptions about the genitalia for a particular gender. There is little data on cancer risk specifically in transsexual individuals. There is difficulty in recommending sex/gender specific screenings (e.g., breast, cervix, ovaries, penis, prostate, testicles and uterus) for transsexual individuals because of their physiologic changes. For example, transmen who have not undergone a mastectomy have the same risks for breast cancer as natal women. In transwomen, the prostate typically is not removed as part of genital surgery, so individuals who do not take feminizing hormones may be at the same risk for prostate cancer as natal men. Therefore, cancer screenings (e.g., mammograms, prostate screenings) may be indicated based on the individual's original gender.

Gender specific screenings may be medically necessary for transgender persons appropriate to their anatomy. Examples include;

1. Breast cancer screening may be medically necessary for transmen persons who have not undergone a mastectomy.

2. Prostate cancer screening may be medically necessary for transwomen who have retained their prostate.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- CPT Coding Table & Instructions
Attachment II- ICD Diagnosis code table & Instructions

NON-SURGICAL TREATMENT

Initiation of feminizing/masculinizing hormone therapy, preferably for members under the age of 18 with parental or legal guardian consent, may be provided after a psychosocial assessment has been conducted and informed consent has been obtained by a health professional.

The criteria for feminizing/masculinizing hormone therapy, are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment
3. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the member's situation and functioning are stable enough to start treatment.

Feminizing/masculinizing hormonal interventions are not without risk for complications, including irreversible physical changes. Medical records should indicate that an extensive evaluation was completed to explore psychological, family and social issues prior to and post treatment. Providers should also document that all information has been provided and understood regarding all aspects associated with the use of cross-sex hormone therapy, including both benefits and risks.

When a service or procedure is medically necessary

Surgical treatment to change primary sexual characteristics for gender dysphoria may be eligible when medical necessity and documentation requirements outlined within this policy are met. All surgical treatments for gender dysphoria require prior approval through BCBSVT.

Surgical treatment for gender dysphoria may be considered medically necessary when **ALL** of the following criteria are met:

- The individual is at least 18 years of age.
- Prior approval is requested and approved.
- A gender reassignment treatment plan is created specific to an individual member and reviewed by a BCBSVT case manager.
- The individual has a documented *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, Text Revision (DSM- 5)* diagnosis of GD.

- 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:

    1. A marked incongruence between one's birth gender and the other gender, or
    2. A strong desire to be rid of one's birth gender, or
    3. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender), or
    4. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender), or
    5. 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)

- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning
- Unless medically contraindicated (or the individual is otherwise unable to take feminizing/masculinizing hormones), there is documentation that the individual has participated in twelve consecutive months of cross-sex hormone therapy of the desired gender continuously and responsibly (e.g., screenings and follow-ups with the professional provider). Hormone therapy is not a pre-requisite for a mastectomy.
- The individual has knowledge of all practical aspects (e.g., required lengths of hospitalizations, likely complications, and post-surgical rehabilitation) of the gender reassignment surgery.
- One current (within the past 12 months) referral letter from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty.)
- Two current (within the past 12 months) referral letters from qualified mental health professionals who have independently assessed the patient's readiness for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent.

Each referral letter for surgery must include the following clinical information:

1. Results of the patient's psychosocial assessment, including any diagnoses.
2. The patient's general identifying characteristics.
3. The duration of the mental health professional's relationship with the patient, including the type of evaluation and therapy or counseling to date.

4. That the patient has completed twelve months of continuous, full-time, real-life experience (i.e., the act of fully adopting a new or evolving gender role or gender presentation in everyday life) in the desired gender, including for example one or more of the following:
    a. Maintain part- or full-time employment; or
    b. Function as a student in an academic setting; or

   c. Function in a community –based volunteer activity.
5. An explanation that the World Professional Association for Transgender Health (WPATH) criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery.

SURGICAL TREATMENTS FOR GENDER REASSIGNMENT

When all of the above criteria are met for gender reassignment surgery, the following genital surgeries may be considered medically necessary for transwomen (male to female):

- Orchiectomy
- Penectomy
- Vaginoplasty
- Clitoroplasty
- Labiaplasty
- Mammaplasty
- Prostatectomy
- Urethroplasty

When all of the above criteria are met for gender reassignment surgery, the following genital/breast surgeries may be considered medically necessary for transmen (female to male):

- Breast reconstruction (e.g., mastectomy)
- Hysterectomy
- Salpingo-oophorectomy
- Vaginectomy
- Vulvectomy
- Metoidioplasty
- Phalloplasty
- Urethroplasty
- Scrotoplasty
- Testicular prostheses implantation

When service or procedure is not medically necessary and therefore not covered

- Services or procedures when medical necessity and documentation requirements outlined within this policy are not met.
- When prior approval is not obtained and approved.
- When services are an exclusion and therefore not covered.

COSMETIC SERVICES

Services for the purpose of changing secondary sexual characteristics are considered cosmetic and contract exclusions for all products of the Plan and therefore not covered. Included but not limited to:

- Liposuction: removal of fat
- Rhinoplasty: reshaping of nose

- Rhytidectomy: face lift
- Blepharoplasty: removal of redundant skin of upper and/or lower eyelids and protruding periorbital fat
- Hair removal/ hair transplantation
- Facial feminizing (e.g., facial bone reduction)
- Chin augmentation: reshaping or enhancing the size of the chin
- Collagen injections
- Lip reduction/enhancement: decreasing/enlarging lip size
- Cricothyroid approximation: voice modification that raises the vocal pitch by simulating contractions of the cricothyroid muscle with sutures
- Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage
- Laryngoplasty: reshaping of laryngeal framework (voice modification surgery)
- Mastopexy: breast lift

For a list of additional services that are considered cosmetic and therefore, non-covered, please refer to our medical policy for Cosmetic and Reconstructive procedures.

Documentation Information

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

See coding tables below for procedures (Attachment I), and diagnosis (Attachment II) which are eligible per this medical policy. Procedures listed below may be eligible when medical necessity and documentation requirements outlined within this policy are met.

BILLING GUIDELINES

When reporting procedure code 55970 (Intersex surgery; male to female), the following staged procedures to remove portions of the male genitalia and form female external genitals are included:

- The penis is dissected, and portions are removed with care to preserve vital nerves and vessels in order to fashion a clitoris-like structure.
- The urethral opening is moved to a position similar to that of a female.
- A vagina is made by dissecting and opening the perineum. This opening is lined using pedicle or split- thickness grafts.
- Labia are created out of skin from the scrotum and adjacent tissue.
- A stent or obturator is usually left in place in the newly created vagina for three weeks or longer.

When reporting procedure code 55980 (Intersex surgery; female to male), the following staged procedures to form a penis and scrotum using pedicle flap grafts and free skin grafts are included:

- Portions of the clitoris are used, as well as the adjacent skin.
- Prostheses are often placed in the penis to create a sexually functional organ.
- Prosthetic testicles are implanted in the scrotum.
- The vagina is closed or removed.

Scientific Background and Reference Resources

1. American College of Obstetricians and Gynecologists (ACOG). Health care for transgendered individuals. 2005. [ACOG Web site]. Available at: http://www.acog.org/publications/specialissuesinwomenshealth/siwh-21.pdf. [Via subscription only]. Accessed October 11, 2010.
2. American Psychiatric Association. *Gender Dysphoria. Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition - Text Revision (DSM-V-TM)*. 5th ed. Arlington, VA: American Psychiatric Publishing, Inc.; 2013: 451-459.
3. American Psychological Association (APA) Task Force on Gender Identity and Gender Variance. 2008. *Report of the Task Force on Gender Identity and Gender Variance*. Washington, DC: American Psychological Association. Also available on the American Urological Association, Inc. Web site at: http://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf. Accessed August 25, 2010.
4. Ashbee O, Goldberg J. Trans people and cancer. [Vancouver Coastal Health Web site]. 02/2006 2. Available at:http://transhealth.vch.ca/resources/library/tcpdocs/consumer/medical-cancer.pdf. Accessed August 25, 2010.
5. Benet A and Melman A. Management of patients with gender dysphoria. In: Hellstrom W, eds. *Male infertility and sexual dysfunction.*New York, NY: Springer-Verlag New York, Inc; 1997: 563-571.
6. Bowman C, Goldberg J. Care of the patient undergoing sex reassignment surgery (SRS). [Vancouver Coastal Health Web site]. 01/2006. Available at: http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-surgery.pdf. Accessed August 25, 2010.
7. ECRI Institute. Sexual reassignment for gender identity disorders. [ECRI Institute Web site]. 12/30/2009. Available at: https://members2.ecri.org/Components/Hotline/Pages/7310.aspx. [via subscription only]. Accessed August 25, 2010.
8. Gender Identity Research and Education Society (GIRES). A guide to lower surgery for trans men. [GIRES website]. Available at: http://www.gires.org.uk/assets/Support-Assets/lower-surgery.pdf. Accessed August 24, 2010.
9. Gibson B. Care of the child with the desire to change genders-part II: female-to-male transition. *Pediatric Nursing*.2010; 36(2):112-118. Also available on the Medscape Web site at: http://www.medscape.com/viewarticle/722004. Accessed August 25, 2010.
10. Gibson B & Catlin AJ. Care of the child with the desire to change gender – Part I. *Pediatric Nursing*. 2010; 36(1): 53–59.
11. Hembree W, Cohen-Kettenis P, Delemarre-van de Waal H, et al. Endocrine treatment of transsexual persons: An endocrine society clinical practice guidelines. *J Clin Endocrinol Metab*.2009; 94(9):3132-3154.

12. Medical treatment options for gender variant adults. [Gender Identity Research and Education Society Web site]. 2010. Available at: http://www.gires.org.uk/vmedtreatment.php. Accessed August 25, 2010.
13. Meyer W, Bockting W, Cohen-Kettenis P, et al. The Harry Benjamin international gender dysphoria association's standards of care for gender identity disorders, seventh version. [The World Professional Association For Transgender Health Web site]. 02/2001. Available at: http://www.wpath.org/documents/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf . Accessed June 3, 2013.
14. The world professional association for transgender health, Inc. (WPATH). Clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A. *WPATH*. 2008; 1-4. Also available on the WPATH Web site at: http://www.tgender.net/taw/WPATHMedNecofSRS.pdf. Accessed August 25, 2010.
15. Vesely J. Gender transformation. [Cosmetic Plastic Surgery Web site]. 03/28/2007. Available at: http://www.cosmetic-plastic-surgery.info/procedures/treatment-of-transsexualism. Accessed August 25, 2010.
16. Zderic S. Sexual identity shifting paradigms for the management of ambiguous genitalia. *AUA*. 2002; 21:162-167. Also available on the American Urological Association, Inc.Web site at: http://www.auanet.org/eforms/elearning/core/topics%5Cpediatrics%5Canomalies%5Cassets%5CUpdateSeries2002-Vol21-Lesson21.pdf. Accessed August 25, 2010.
17. Meyer W, Bockting W, Cohen-Kettenis P, et al. The Harry Benjamin international gender dysphoria association's standards of care for gender identity disorders, seventh version. [The World Professional Association For Transgender Health Web site]. 02/2001. Available at: http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf Accessed October 1, 2015.

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services (ASO) only group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

Date Updated:	Notes:
05/30/2011	New Policy- UVM Coverage only. Excluded from all other contracts.
10/2012	Minor format changes. No coding changes. Medical/Clinical Coder reviewed.
05/2013	Reviewed for health exchange/ new DFR regulation. "Unfair discrimination", Insurance Bulletin No. 174. Added coding tables for CPT and ICD-9 and ICD-10. Removed language that was specific to UVM group coverage and removed language pertaining to GD/Transgender exclusions since the exclusions no longer apply. RLJ.
06/2016	Changes made based on WPATH standards of care. Hormone Therapy clarified. Diagnosis codes added.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s) to include:

- Medical Doctors- MD
- Doctors of Osteopathy-DO

Approved by BCBSVT Health & Payment Policy Committee Date Approved

Joshua Plavin, MD
Senior Medical Director
Chair, Health & Payment Policy Committee

Robert Wheeler, MD
Chief Medical Officer

Attachment I
CPT Coding Table & Instructions

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
Transwoman procedures (male to female)			
CPT	19325	Mammaplasty, augmentation; with prosthetic implant	Prior approval required
CPT	19350	Nipple/areola reconstruction	Prior approval required
CPT	54125	Amputation of penis; complete	Prior approval required
CPT	54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	Prior approval required
CPT	54690	Laparoscopy, surgical; orchiectomy	Prior approval required
CPT	55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed.	Prior approval required

CPT	55970	Intersex change; male to female	See "Billing Guidelines" section of this medical policy for instructions on this code. Prior approval required
CPT	56800	Plastic repair of introitus	Prior approval required
CPT	56805	Clitoroplasty for intersex state	Prior approval required
CPT	57291	Construction of artificial vagina; without graft	Prior approval required
CPT	57292	Construction of artificial vagina; with graft	Prior approval required
CPT	57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	Prior approval required
CPT	57296	Revision (including removal) of prosthetic vaginal graft, open abdominal approach	Prior approval required
CPT	57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach (out of numeric sequence)	Prior approval required
CPT	57335	Vaginoplasty for intersex state	Prior approval required
CPT	53430	Urethroplasty	Prior approval required
Transman procedures (female to male)			
CPT	19303	Mastectomy, simple, complete	Prior approval required
CPT	19304	Mastectomy, subcutaneous	Prior approval required
CPT	19350	Nipple/areola reconstruction	Prior approval required
CPT	53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage	Prior approval required
cpt	53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage	Prior approval required
CPT	54660	Insertion of testicular prosthesis (separate procedure)	Prior approval required

CPT	55175	Scrotoplasty; simple	Prior approval required
CPT	55180	Scrotoplasty; complicated	Prior approval required
CPT	55980	Intersex change; female to male	See "Billing Guidelines" section of this medical policy for instructions on this code. Prior approval required
CPT	56625	Vulvectomy simple; complete	Prior approval required
CPT	57106	Vaginectomy, partial removal of vaginal wall	Prior approval required
CPT	57110	Vaginectomy, complete removal of vaginal wall	Prior approval required
CPT	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tubes(s), with or without removal of ovary(s)	Prior approval required
CPT	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Prior approval required
CPT	58260	Vaginal hysterectomy, for uterus 250g or less;	Prior approval required
CPT	58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tubes(s) and/or ovary(s)	Prior approval required
CPT	58275	Vaginal hysterectomy, with total or partial vaginectomy;	Prior approval required
CPT	58290	Vaginal hysterectomy, for uterus greater than 250g;	Prior approval required
CPT	58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tubes(s) and/or ovary(s)	Prior approval required
CPT	58541	Laparoscoy, surgical, supracervical hysterectomy, for uterus 250g or less;	Prior approval required

CPT	58542	Laparoscoy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58543	Laparoscoy, surgical, supracervical hysterectomy, for uterus greater than 250g;	Prior approval required
CPT	58544	Laparoscoy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less;	Prior approval required
CPT	58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less;	Prior approval required
CPT	58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g;	Prior approval required

CPT	58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral	Prior approval required
The following codes are considered cosmetic and will be denied as contract exclusions, therefore not covered. (this list may not be all-inclusive)			
CPT	11950-11954	Subcutaneous injection of filling material (eg, collagen)	Code range not covered
CPT	15775-15776	Punch graft for hair transplant	Code range not covered
CPT	15820-15823	Blepharoplasty	Code range not covered
CPT	15824-15829	Rhytidectomy	Code range not covered
CPT	15830-15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)	Code range not covered
CPT	15876-15879	Liposuction	Code range not covered
CPT	17380	Electrolysis epilation	This includes laser hair removal
CPT	19316	Mastopexy	
CPT	21120-21123	Genioplasty- Chin augmentation	Code range not covered
CPT	21125-21127	Augmentation, mandibular body or angle	Code range not covered
CPT	21208-21209	Osteoplasty, facial bones; augmentation or reduction	Code range not covered
CPT	30400-30450	Rhinoplasty	Code range not covered
CPT	31587	Laryngoplasty, cricoid split	Code range not covered
All unlisted procedure codes will suspend for medical review			

Type of Service	Surgery
Place of Service	Inpatient

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
Transwoman procedures (male to female)			
CPT	19325	Mammaplasty, augmentation; with prosthetic implant	Prior approval required
CPT	54125	Amputation of penis; complete	Prior approval required
CPT	54520	Orchiectomy, simple (including sub capsular), with or without testicular prosthesis, scrotal or inguinal approach	Prior approval required
CPT	54690	Laparoscopy, surgical; orchiectomy	Prior approval required
CPT	55866	Laparoscopy, surgical prostatectomy, retro pubic radical, including nerve sparing, includes robotic assistance, when performed.	Prior approval required
CPT	55970	Intersex change; male to female	See "Billing Guidelines" section of this medical policy for instructions on this code. Prior approval required
CPT	56800	Plastic repair of introitus	Prior approval required
CPT	56805	Clitoroplasty for intersex state	Prior approval required
CPT	57291	Construction of artificial vagina; without graft	Prior approval required
CPT	57292	Construction of artificial vagina; with graft	Prior approval required
CPT	57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	Prior approval required

CPT	57296	Revision (including removal) of prosthetic vaginal graft, open abdominal approach	Prior approval required
CPT	57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach (out of numeric sequence)	Prior approval required
CPT	57335	Vaginoplasty for intersex state	Prior approval required
CPT	53430	Urethroplasty	Prior approval required
Transman procedures (female to male)			
CPT	19303	Mastectomy, simple, complete	Prior approval required
CPT	19304	Mastectomy, subcutaneous	Prior approval required
CPT	53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage	Prior approval required
CPT	53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage	Prior approval required
CPT	54660	Insertion of testicular prosthesis (separate procedure)	Prior approval required
CPT	55175	Scrotoplasty; simple	Prior approval required
CPT	55180	Scrotoplasty; complicated	Prior approval required
CPT	55980	Intersex change; female to male	See "Billing Guidelines" section of this medical policy for instructions on this code. Prior approval required
CPT	56625	Vulvectomy simple; complete	Prior approval required
CPT	57106	Vaginectomy, partial removal of vaginal wall	Prior approval required
CPT	57110	Vaginectomy, complete removal of vaginal wall	Prior approval required

CPT	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tubes(s), with or without removal of ovary(s)	Prior approval required
CPT	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Prior approval required
CPT	58260	Vaginal hysterectomy, for uterus 250g or less;	Prior approval required
CPT	58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tubes(s) and/or ovary(s)	Prior approval required
CPT	58275	Vaginal hysterectomy, with total or partial vaginectomy;	Prior approval required
CPT	58290	Vaginal hysterectomy, for uterus greater than 250g;	Prior approval required
CPT	58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tubes(s) and/or ovary(s)	Prior approval required
CPT	58541	Laparoscoy, surgical, supracervical hysterectomy, for uterus 250g or less;	Prior approval required
CPT	58542	Laparoscoy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58543	Laparoscoy, surgical, supracervical hysterectomy, for uterus greater than 250g;	Prior approval required
CPT	58544	Laparoscoy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less;	Prior approval required

CPT	58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less;	Prior approval required
CPT	58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g;	Prior approval required
CPT	58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval required
CPT	58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral	Prior approval required
The following codes are considered cosmetic and will be denied as contract exclusions, therefore not covered. (this list may not be all-inclusive)			
CPT	11950-11954	Subcutaneous injection of filling material (eg, collagen)	Code range not covered
CPT	15775-15776	Punch graft for hair transplant	Code range not covered
CPT	15820-15823	Blepharoplasty	Code range not covered

CPT	15824-15829	Rhytidectomy	Code range not covered
CPT	15830-15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)	Code range not covered
CPT	15876-15879	Liposuction	Code range not covered
CPT	17380	Electrolysis epilation	This includes laser hair removal
CPT	19316	Mastopexy	
CPT	19350	Nipple/areola reconstruction	
CPT	21120-21123	Genioplasty- Chin augmentation	Code range not covered
CPT	21125-21127	Augmentation, mandibular body or angle	Code range not covered
CPT	21208-21209	Osteoplasty, facial bones; augmentation or reduction	Code range not covered
CPT	30400-30450	Rhinoplasty	Code range not covered
CPT	31587	Laryngoplasty, cricoid split	Code range not covered
All unlisted procedure codes will suspend for medical review			
Type of Service	Surgery		
Place of Service	Inpatient		

Attachment II

ICD Diagnosis code table & Instructions

Code Type	Number	Description	Policy Instructions
The following diagnosis codes are considered medically necessary when applicable criteria have been met.			
ICD-10	F64.1	Gender identity disorder in adolescence and adulthood	Use additional code to identify sex reassignment surgery status (Z87.890)
ICD-10	F64.2	Gender identity disorder of childhood	
ICD-10	F64.8	Other gender identity disorders	

ICD-10	F64.9	Gender identity disorder, unspecified	