Medical Coverage Policy

Effective Date .............................................. 4/15/2019
Next Review Date .......................................... 3/15/2020
Coverage Policy Number ................................. 0266

Overview

This Coverage Policy addresses treatment of gender dysphoria. Gender dysphoria is defined as discomfort or distress that is caused by a discrepancy between a person’s gender identity and the person’s assigned sex at birth (World Professional Association for Transgender Health, [WPATH], 2012).

Coverage Policy

Coverage for treatment of gender dysphoria varies across plans. Refer to the customer’s benefit plan document for coverage details. Coverage for treatment of gender dysphoria, including gender reassignment surgery and related may be governed by state and/or federal mandates.
Unless otherwise specified in a benefit plan, the following conditions of coverage apply for treatment of gender dysphoria and/or gender reassignment surgery and related procedures, including all applicable benefit limitations, precertification, or other medical necessity criteria.

**SERVICES MEDICALLY NECESSARY**
Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:

- Behavioral health services, including but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression)
- Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues, estrogens, and progestins.
- Laboratory testing to monitor prescribed hormonal therapy
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individual's biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition)
- Gender reassignment and related surgery (see below).

**Gender Reassignment Surgery**

Gender reassignment surgery (see Table 1) is considered medically necessary treatment of gender dysphoria when the individual is age 18 years or older and when the following criteria are met:

- **For initial mastectomy:** one letter of support from a qualified mental health professional

  NOTE: The Women's Health and Cancer Rights Act (WHCRA), 29 U.S. Code § 1185b requires coverage of certain post-mastectomy services related to breast reconstruction and treatment of physical complications from mastectomy including nipple-areola reconstruction.

- **For hysterectomy, salpingo-oophorectomy, orchiectomy:**
  - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
  - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required.

- **For reconstructive genital surgery:**
  - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
  - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required AND
  - documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity.

**Table 1: Gender Reassignment Surgery**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT / HCPCS codes (This list may not be all inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial mastectomy*, nipple-areola reconstruction (related to mastectomy or post mastectomy reconstruction)</td>
<td>19303, 19304, 19350</td>
</tr>
<tr>
<td>Hysterectomy and salpingo-oophorectomy</td>
<td>58150, 58260 58262 58291, 58552, 58554,</td>
</tr>
</tbody>
</table>
Female to male reconstructive genital surgery which may include any of the following:

- Vaginectomy***/colpectomy
- Vulvectomy
- Metoidioplasty
- Phalloplasty
- Electrolysis of donor site tissue to be used for phalloplasty
- Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir
- Urethroplasty / urethromeatoplasty

Male to female reconstructive genital surgery, which may include any of the following:

- Vaginoplasty***, (e.g. construction of vagina with/without graft, colovaginoplasty)
- Electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty
- Penectomy
- Vulvoplasty, (e.g., labiaplasty, clitoroplasty, penile skin inversion)
- Repair of introitus
- Coloproctostomy

*Note: Please reference the Cigna Medical Coverage Policy 0152 Reduction Mammaplasty for conditions of coverage related to breast reduction.

**Note: For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment therapy is required. An additional 12 months of hormone therapy is not required for vaginectomy or vaginoplasty procedures.

NOT MEDICALLY NECESSARY SERVICES
Gender reassignment surgery is considered not medically necessary when the applicable medical necessity criteria for the procedure(s) has not been met.

Each of the following is excluded under many benefit plans and/or considered not medically necessary as part of gender reassignment for preservation of fertility (see Table 2):

**Table 2** Excluded and/or Not Medically Necessary- Fertility Preservation

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT/HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryopreservation of embryo, sperm, oocytes</td>
<td>89258, 89259, 89337</td>
</tr>
<tr>
<td>Procurement of embryo, sperm, oocytes</td>
<td>S4030, S4031</td>
</tr>
<tr>
<td>Storage of embryo, sperm, oocytes</td>
<td>89342, 89343, 89346, S4027, S4040</td>
</tr>
</tbody>
</table>

EXPERIMENTAL / INVESTIGATIONAL/UNPROVEN SERVICES
Each of the following is considered experimental, investigational or unproven as part of gender reassignment for the preservation of fertility (see Table 3):
### Table: 3 Experimental, Investigational or Unproven - Fertility Preservation

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT/HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryopreservation of immature oocytes</td>
<td>0357T</td>
</tr>
<tr>
<td>Cryopreservation of reproductive tissue (i.e., ovaries, testicular tissue)</td>
<td>89335, 0058T</td>
</tr>
<tr>
<td>Storage of reproductive tissue (i.e., ovaries, testicular tissue)</td>
<td>89344</td>
</tr>
<tr>
<td>Thawing of reproductive tissue (i.e., ovaries, testicular tissue)</td>
<td>89354</td>
</tr>
</tbody>
</table>

### COSMETIC SERVICES

Each of the following services (see Table 4) is considered cosmetic and/or not medically necessary for the purpose of improving or altering appearance or self-esteem related to one’s appearance, including gender specific appearance for an individual with gender dysphoria:

### Table 4: Cosmetic and/or Not Medically Necessary (Unless coverage is specifically listed as available in the applicable benefit plan document)

<table>
<thead>
<tr>
<th>Facial Feminization/Masculinization Procedures</th>
<th>CPT/HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blepharoplasty</td>
<td>15820, 15821, 15822, 15823</td>
</tr>
<tr>
<td>Cheek/malar implants</td>
<td>17999</td>
</tr>
<tr>
<td>Chin/nose implants</td>
<td>21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450</td>
</tr>
<tr>
<td>Collagen injections</td>
<td>11950, 11951, 11952, 11954</td>
</tr>
<tr>
<td>Face/forehead lift</td>
<td>15824, 15825, 15826, 15828, 15829, 21137</td>
</tr>
<tr>
<td>Facial bone reduction (osteoplasty)</td>
<td>21209</td>
</tr>
<tr>
<td>Hair removal/hair transplantation</td>
<td>15775, 15776, 17380</td>
</tr>
<tr>
<td>Jaw reduction</td>
<td>21120, 21121, 21122, 21123, 21125, 21127</td>
</tr>
<tr>
<td>Laryngoplasty</td>
<td>31599</td>
</tr>
<tr>
<td>Rhinoplasty</td>
<td>21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450</td>
</tr>
<tr>
<td>Skin resurfacing (e.g., dermabrasion, chemical peels)</td>
<td>15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793</td>
</tr>
<tr>
<td>Thyroid reduction chondroplasty</td>
<td>31750</td>
</tr>
<tr>
<td>Neck tightening</td>
<td>15825</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chest Reconstruction Procedures</th>
<th>CPT/HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast augmentation with implants</td>
<td>19324, 19325, 19340, 19342, C1789</td>
</tr>
<tr>
<td>Mastopexy</td>
<td>19316</td>
</tr>
<tr>
<td>Nipple/areola reconstruction (unrelated to mastectomy or post mastectomy reconstruction)</td>
<td>19350</td>
</tr>
<tr>
<td>Pectoral Implants</td>
<td>L8600, 17999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Voice Modification Therapy/Procedures</th>
<th>CPT/HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice modification surgery</td>
<td>31599, 31899</td>
</tr>
<tr>
<td>Voice therapy/voice lessons</td>
<td>92507</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Miscellaneous Procedures</th>
<th>CPT/HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty</td>
<td>15847</td>
</tr>
</tbody>
</table>
General Background

The causes of gender dysphoria and the developmental factors associated with them are not well-understood. Treatment of individuals with gender dysphoria varies, with some treatments involving a change in gender expression or body modifications. The term “transsexual” refers to an individual whose gender identity is not congruent with their genetic and/or assigned sex and usually seeks hormone replacement therapy (HRT) and possibly gender-affirmation surgery to feminize or masculinize the body and who may live full-time in the crossgender role. Transsexualism is a form of gender dysphoria. Other differential diagnoses include, but are not limited to, partial or temporary disorders as seen in adolescent crisis, transvestitism, refusal to accept a homosexual orientation, psychotic misjudgments of gender identity and severe personality disorders (Becker, et al., 1998). Individuals that are transsexual, transgender, or gender nonconforming (i.e., gender identity differs from the cultural norm) may experience gender dysphoria.

Treatment of gender dysphoria is unique to each individual and may or may not involve body modifications. Some individuals require only psychotherapy, some require a change in gender roles/expression, and others require hormone therapy and/or surgery to facilitate a gender transition.

Behavioral Health Services

Licensing requirements and scope of practice vary by state for healthcare professionals. WPATH has defined recommended minimum credentials for a mental health professional to be qualified to evaluate or treat adult individuals with gender dysphoria. In addition to general licensing requirements, WPATH includes a minimum of a Master's or more advanced degree from an accredited institution, an ability to recognize and diagnose coexisting mental health concerns, and an ability to distinguish such conditions from gender dysphoria. Mental health professionals play a strong role in working with individuals with gender dysphoria as they need to diagnose the gender disorder and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, and provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. For children and adolescents, the mental health professional should also be trained in child and adolescent developmental psychopathology.

Once the individual is evaluated, the mental health professional provides documentation and formal recommendations to medical and surgical specialists. Documentation for hormonal and/or surgery should be comprehensive and include the extent to which eligibility criteria have been met (i.e., confirmed gender dysphoria, capacity to make a fully informed decision, age ≥ 18 years or age of majority, and other significant medical or behavioral health concerns are well-controlled), in addition to the following:

- individual’s general identifying characteristics
- the initial and evolving gender, sexual and psychiatric diagnoses
- details regarding the type and duration of psychotherapy or evaluation the individual received
- the mental health professional’s rationale for hormone therapy or surgery
- the degree to which the individual has followed the standards of care and likelihood of continued compliance
whether or not the mental health professional is a part of a gender team

For breast surgery WPATH Standards of Care Version 7 require one referral from a qualified mental health professional, as defined above. For genital surgery WPATH requires two referrals from qualified mental health professionals indicating criteria for surgery has been met. In contrast, the Endocrine Society Clinical Practice Guidelines (Hembree, et al., 2009) recommend both an endocrinologist responsible for endocrine transition therapy and a mental health professional certify the individual is eligible and meets WPATH criteria for gender reassignment surgery.

Psychiatric care may need to continue for several years after gender reassignment surgery, as major psychological adjustments may continue to be necessary. Other providers of care may include a family physician or internist, endocrinologist, urologist, plastic surgeon, general surgeon and gynecologist. The overall success of the surgery is highly dependent on psychological adjustment and continued support.

After diagnosis, the therapeutic approach is individualized but generally includes three elements: sex hormone therapy of the identified gender, real life experience in the desired role, and surgery to change the genitalia and other sex characteristics.

Hormonal Therapy
For both adults and adolescents, hormonal treatment for gender dysphoria must be administered and monitored by a qualified healthcare practitioner as therapy requires ongoing medical management, including physical examination and laboratory evaluation studies to manage dosage, side effects, etc. Lifelong maintenance is usually required.

Adults: Prior to and following gender reassignment surgery, individuals undergo hormone replacement therapy, unless medically contraindicated. Biological males are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Biological females are treated with androgens such as testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes hormone replacement therapy (HRT) may be effective in reducing the adverse psychologic impact of gender dysphoria. Hormone therapy is usually initiated upon referral from a qualified mental health professional or a health professional competent in behavioral health and gender dysphoria treatment specifically. Twelve months of continuous hormone therapy (gender appropriate) is required prior to hysterectomy and salpingo-oophorectomy and orchietomy.

Adolescents: Puberty-suppressing hormones (e.g., GnRH analogues) for adolescents may be provided to individuals who have reached at least Tanner stage 2 of sexual development. The Endocrine Society supports puberty suppression and has developed criteria for a subset of individuals who fulfill and meet eligibility readiness for gender reassignment (Hembree, et al., 2009). WPATH clinical recommendations also support puberty suppression (WPATH, 2012) for a similar subset of individuals. Consistent with adult hormone therapy, treatment of adolescents involves a multidisciplinary team, however when treating an adolescent a pediatric endocrinologist should be included as a part of the team. Pre-pubertal hormone suppression differs from hormone therapy used in adults and may not be without consequence; some pharmaceutical agents may cause negative physical side effects (e.g., height, bone growth).

Gender Reassignment Surgery
The term "gender reassignment surgery," also known as sexual reassignment surgery, gender confirming surgery or gender affirmation surgery, may be part of a treatment plan for gender dysphoria. The terms may be used to refer to either the reconstruction of male or female genitalia specifically, or the reshaping by any surgical procedure of a male body into a body with female appearance, or vice versa.

Gender identity disorder does not persist into adolescence in most children (Hembree, et al., 2009). Evidence suggests that 75-80% of prepubertal children do not turn out to be transsexual in adolescence (Hembree, et al., 2009). According to WPATH (2007) persistence of gender dysphoria from adolescence into adulthood is much higher. Performing gender reassignment surgery prior to age 18, or the legal age to give consent, is not recommended by professional societies (American College of Obstetricians and Gynecology [ACOG], 2017;
Gender reassignment surgery is intended to be a permanent change (non-reversible), establishing congruency between an individual’s gender identity and physical appearance. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine and urological examination, and a clinical psychiatric/psychological examination. Individuals who choose to undergo gender reassignment surgery must be fully informed regarding treatment options with confirmation from the mental health professional that the individual is considered a candidate for surgical treatment.

Twelve months of continuous hormone therapy is required prior to irreversible genital surgery. In addition, prior to surgery the individual identified with gender dysphoria must undergo a “real life experience,” in which he/she adopts the new or evolving gender role and lives in that role for at least 12 continuous months as part of the transition pathway. This process assists in confirming the person’s desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During this time, a person would be expected to maintain their baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Other Associated Surgical Procedures
Services Otherwise Medically Necessary: Age appropriate gender-specific services that would otherwise be considered medically necessary remain medically necessary services for transgender individuals, as appropriate to their biological anatomy. Examples include (but are not limited to):
- for female to male transgender individuals who have not undergone a mastectomy, breast cancer and cervical cancer screening
- for male to female transgender individuals who have retained their prostate cancer screening or treatment of a prostate condition.

Reversal of Gender Reassignment: Gender reassignment surgery is considered an irreversible intervention (WPATH, 2012). Although infrequent, surgery to reverse a partially or fully completed gender reassignment (reversal of surgery to revise secondary sex characteristics), may be necessary as a result of a complication (i.e., infection) or other medical condition necessitating surgical intervention.

Fertility Preservation: Both hormone therapy and gender reassignment surgery limits fertility, and individuals should be informed of sperm preservation options and other cryopreservation services prior to starting hormone therapy. Reproductive options should also be discussed prior to surgery for individuals who are of child-bearing age. However, procedures aimed at preservation of fertility (e.g., procurement, cryopreservation, and storage of sperm, oocytes and/or embryos) performed prior to gender reassignment surgery are considered not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Cosmetic Procedures: Various other surgical procedures may be performed as part of gender reassignment surgery. Although WPATH does not define medical necessity criteria for masculinization and feminization procedures, referral by a qualified mental health professional is recommended. When performed as part of gender reassignment surgery such procedures, aimed primarily at improving personal appearance (i.e., masculinization, feminization), are performed to assist with improving culturally appropriate male or female appearance characteristics and are therefore considered cosmetic and are not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Professional Society/Organization
American College of Obstetricians and Gynecologists (ACOG): ACOG published a Committee Opinion in 2017 for the care of transgender adolescents. Within this document regarding surgical management ACOG notes transgender male patients may undergo phalloplasty when one reaches the age of majority, and a transgender female patient may undergo vaginoplasty when one reaches the age of majority. In addition the authors acknowledge the Endocrine Society guidelines (Hembree, et al., 2009) which state that an individual is at least age 18 years for genital reconstructive surgery (ACOG, 2017).
American Psychiatric Association (APA): In 2012 the APA published a task force report on treatment of gender identity disorder. Within this document, regarding adolescents specifically, the authors state the evidence is inadequate to develop a guideline regarding the timing of sex reassignment surgery. However the task force acknowledges the Endocrine Society guidelines (Hembree, et al., 2009) and that given the irreversible nature of surgery, for adolescents most clinicians advise waiting until the individual has attained the age of legal consent and a degree of independence (APA, 2012).

WPATH Standards of Care: The World Professional Association for Transgender Health (WPATH) promotes standards of health care for individuals through the articulation of “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People” (WPATH, 2012, Version 7). WPATH standards of care are based on scientific evidence and expert consensus and are commonly utilized as clinical recommendations for individuals seeking treatment of gender disorders.

Endocrine Society: In 2009 the Endocrine Society published a clinical practice guideline for endocrine treatment of transsexual persons (Hembree, et al., 2009). As part of this guideline, the endocrine society recommends that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery advisable; that surgery be recommended only after completion of at least one year of consistent and compliant hormone treatment; and that the physician responsible for endocrine treatment medically clear the individual for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery.

Centers for Medicare & Medicaid Services (CMS)
- National Coverage Determination (NCD): No NCD found.
- Local Coverage Determination (LCD): No LCD found.

Use Outside of the US: Several other countries including the United Kingdom offer treatment options for individuals with gender dysphoria. Treatments are similar to those offered in the United States.

**Coding/Billing Information**

**Note:** 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Intersex Surgery: Male to Female**

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55970†</td>
<td>Intersex surgery; male to female</td>
</tr>
<tr>
<td>†Includes only the following procedures:</td>
<td></td>
</tr>
<tr>
<td>44145</td>
<td>Colectomy, partial; with coloproctostomy (low pelvic anastomosis)</td>
</tr>
<tr>
<td>554125</td>
<td>Amputation of penis; complete</td>
</tr>
<tr>
<td>54520</td>
<td>Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach</td>
</tr>
<tr>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy</td>
</tr>
<tr>
<td>55899††</td>
<td>Unlisted procedure, male genital system</td>
</tr>
<tr>
<td>56620</td>
<td>Vulvectomy simple; partial</td>
</tr>
<tr>
<td>56800</td>
<td>Plastic repair of introitus</td>
</tr>
<tr>
<td>56805</td>
<td>Clitoroplasty for intersex state</td>
</tr>
<tr>
<td>57291</td>
<td>Construction of artificial vagina; without graft</td>
</tr>
<tr>
<td>57292</td>
<td>Construction of artificial vagina; with graft</td>
</tr>
<tr>
<td>57335</td>
<td>Vaginoplasty for intersex state</td>
</tr>
</tbody>
</table>
††Note: Considered medically necessary when used to report Coloproctostomy.

**Intersex Surgery: Female to Male**

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55980†</td>
<td>Intersex surgery, female to male</td>
</tr>
</tbody>
</table>

†Includes only the following procedures:

19303      | Mastectomy, simple, complete |
19304      | Mastectomy, subcutaneous |
19350††    | Nipple/areola reconstruction |
53430      | Urethroplasty, reconstruction of female urethra |
53450      | Urethromeatoplasty, with mucosal advancement |
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 |
56625      | Vulvectomy simple; complete |
57110      | Vaginectomy, complete removal of vaginal wall |
58150      | Total abdominal hysterectomy (corpus and cervix), 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) |
58291      | Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
58552      | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |
58554      | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
58571      | Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |
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) |
58999†††   | Unlisted procedure, female genital system (nonobstetrical) |

††Note: Considered medically necessary when performed as part of a mastectomy or breast reconstruction procedure following a mastectomy.

†††Note: Considered medically necessary when used to report metoidioplasty with phalloplasty.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1813</td>
<td>Prosthesis, penile, inflatable</td>
</tr>
<tr>
<td>C2622</td>
<td>Prosthesis, penile, non-inflatable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F64.0</td>
<td>Trans-sexualism</td>
</tr>
</tbody>
</table>
Generally Excluded/Not Medically Necessary:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>89258</td>
<td>Cryopreservation; embryo(s)</td>
</tr>
<tr>
<td>89259</td>
<td>Cryopreservation; sperm</td>
</tr>
<tr>
<td>89337</td>
<td>Cryopreservation, mature oocyte(s)</td>
</tr>
<tr>
<td>89342</td>
<td>Storage (per year); embryo(s)</td>
</tr>
<tr>
<td>89343</td>
<td>Storage (per year); sperm/semen</td>
</tr>
<tr>
<td>89346</td>
<td>Storage (per year); oocyte(s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S4027</td>
<td>Storage of previously frozen embryos</td>
</tr>
<tr>
<td>S4030</td>
<td>Sperm procurement and cryopreservation services; initial visit</td>
</tr>
<tr>
<td>S4031</td>
<td>Sperm procurement and cryopreservation services; subsequent visit</td>
</tr>
<tr>
<td>S4040</td>
<td>Monitoring and storage of cryopreserved embryos, per 30 days</td>
</tr>
</tbody>
</table>

Considered Experimental/Investigational/Unproven:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>89335</td>
<td>Cryopreservation, reproductive tissue, testicular</td>
</tr>
<tr>
<td>89344</td>
<td>Storage (per year); reproductive tissue, testicular/ovarian</td>
</tr>
<tr>
<td>89354</td>
<td>Thawing of cryopreserved; reproductive tissue, testicular/ovarian</td>
</tr>
<tr>
<td>0058T</td>
<td>Cryopreservation; reproductive tissue, ovarian</td>
</tr>
<tr>
<td>0357T</td>
<td>Cryopreservation; immature oocyte(s)</td>
</tr>
</tbody>
</table>

Considered Cosmetic and/or not medically necessary when performed as a component of gender reassignment, even when coverage for gender reassignment surgery exists unless subject to a coverage mandate:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11950</td>
<td>Subcutaneous injection of filling material (eg, collagen); 1 cc or less</td>
</tr>
<tr>
<td>11951</td>
<td>Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc</td>
</tr>
<tr>
<td>11952</td>
<td>Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc</td>
</tr>
<tr>
<td>11954</td>
<td>Subcutaneous injection of filling material (eg, collagen); over 10.0 cc</td>
</tr>
<tr>
<td>11960</td>
<td>Insertion of tissue expander(s) for other than breast, including subsequent expansion</td>
</tr>
<tr>
<td>11970</td>
<td>Replacement of tissue expander with permanent prosthesis</td>
</tr>
<tr>
<td>11971</td>
<td>Removal of tissue expander(s) without insertion of prosthesis</td>
</tr>
<tr>
<td>15775</td>
<td>Punch graft for hair transplant; 1 to 15 punch grafts</td>
</tr>
<tr>
<td>15776</td>
<td>Punch graft for hair transplant; more than 15 punch grafts</td>
</tr>
<tr>
<td>15780</td>
<td>Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)</td>
</tr>
<tr>
<td>15781</td>
<td>Dermabrasion; segmental, face</td>
</tr>
<tr>
<td>15782</td>
<td>Dermabrasion; regional, other than face</td>
</tr>
<tr>
<td>15783</td>
<td>Dermabrasion; superficial, any site (eg, tattoo removal)</td>
</tr>
<tr>
<td>15786</td>
<td>Abrasion; single lesion (eg, keratosis, scar)</td>
</tr>
</tbody>
</table>
| 15787      | Abrasion; each additional 4 lesions or less (List separately in addition to code for primary
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15788</td>
<td>Chemical peel, facial; epidermal</td>
</tr>
<tr>
<td>15789</td>
<td>Chemical peel, facial; dermal</td>
</tr>
<tr>
<td>15792</td>
<td>Chemical peel, nonfacial; epidermal</td>
</tr>
<tr>
<td>15793</td>
<td>Chemical peel, nonfacial; dermal</td>
</tr>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid with extensive herniated fat pad</td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
</tr>
<tr>
<td>15824</td>
<td>Rhytidectomy, forehead</td>
</tr>
<tr>
<td>15825</td>
<td>Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)</td>
</tr>
<tr>
<td>15826</td>
<td>Rhytidectomy; glabellar frown lines</td>
</tr>
<tr>
<td>15828</td>
<td>Rhytidectomy; cheek, chin, and neck</td>
</tr>
<tr>
<td>15829</td>
<td>Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap</td>
</tr>
<tr>
<td>15830</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy</td>
</tr>
<tr>
<td>15832</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</td>
</tr>
<tr>
<td>15833</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg</td>
</tr>
<tr>
<td>15834</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip</td>
</tr>
<tr>
<td>15835</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock</td>
</tr>
<tr>
<td>15836</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm</td>
</tr>
<tr>
<td>15837</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand</td>
</tr>
<tr>
<td>15838</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad</td>
</tr>
<tr>
<td>15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</td>
</tr>
<tr>
<td>15847</td>
<td>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)</td>
</tr>
<tr>
<td>15876</td>
<td>Suction assisted lipectomy; head and neck</td>
</tr>
<tr>
<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
</tr>
<tr>
<td>15878</td>
<td>Suction assisted lipectomy; upper extremity</td>
</tr>
<tr>
<td>15879</td>
<td>Suction assisted lipectomy; lower extremity</td>
</tr>
<tr>
<td>17380</td>
<td>Electrolysis epilation, each 30 minutes</td>
</tr>
<tr>
<td>17999†</td>
<td>Unlisted procedure, skin, mucous membrane and subcutaneous tissue</td>
</tr>
<tr>
<td>19316</td>
<td>Mastopexy</td>
</tr>
<tr>
<td>19324</td>
<td>Mammaplasty, augmentation; without prosthetic implant</td>
</tr>
<tr>
<td>19325</td>
<td>Mammaplasty, augmentation; with prosthetic implant</td>
</tr>
<tr>
<td>19340</td>
<td>Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
</tr>
<tr>
<td>19342</td>
<td>Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
</tr>
<tr>
<td>19350††</td>
<td>Nipple/areola reconstruction</td>
</tr>
<tr>
<td>21120</td>
<td>Genioplasty; augmentation (autograft, allograft, prosthetic material)</td>
</tr>
<tr>
<td>21121</td>
<td>Genioplasty; sliding osteotomy, single piece</td>
</tr>
<tr>
<td>21122</td>
<td>Genioplasty; sliding ostotomies, 2 or more ostotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)</td>
</tr>
<tr>
<td>21123</td>
<td>Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21125</td>
<td>Augmentation, mandibular body or angle; prosthetic material</td>
</tr>
<tr>
<td>21127</td>
<td>Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)</td>
</tr>
<tr>
<td>21137</td>
<td>Reduction forehead; contouring only</td>
</tr>
<tr>
<td>21209</td>
<td>Osteoplasty, facial bones; reduction</td>
</tr>
<tr>
<td>21210</td>
<td>Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)</td>
</tr>
<tr>
<td>21270</td>
<td>Malar augmentation, prosthetic material</td>
</tr>
<tr>
<td>30400</td>
<td>Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip</td>
</tr>
</tbody>
</table>
Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

Rhinoplasty, primary; including major septal repair

Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)

Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)

Unlisted procedure, larynx

Tracheoplasty; cervical

Unlisted procedure, trachea, bronchi

Unlisted procedure, lips

Insertion of testicular prosthesis (separate procedure)

Scrotoplasty; simple

Scrotoplasty; complicated

Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1789</td>
<td>Prosthesis, breast (implantable)</td>
</tr>
<tr>
<td>L8600</td>
<td>Implantable breast prosthesis, silicone or equal</td>
</tr>
</tbody>
</table>

†Note: Cosmetic and/or not medically necessary when used to report calf, cheek, malar or pectoral implants or fat transfers performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

††Note: Cosmetic and/or not medically necessary when not performed as part of a mastectomy or breast reconstructive procedure.

†††Note: Cosmetic and/or not medically necessary when used to report laryngoplasty performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

††††Note: Cosmetic and/or not medically necessary when used to report voice modification surgery performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

†††††Note: Cosmetic and/or not medically necessary when used to report lip reduction/enhancement performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.


References


