Clinical Policy: Gender-Affirming Procedures

Reference Number: CP.MP.95
Last Review Date: 10/19

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 surgery when such services are included under the members’ benefit plan contract provisions.

Policy/Criteria
It is the policy of Health Plans affiliated with Centene Corporation® that the gender-affirming surgeries listed in section III are considered medically necessary for members when diagnosed with gender dysphoria per criteria in section I and when meeting the eligibility criteria in section II.

I. Gender Dysphoria Criteria, meets A and B
A. Marked incongruence between the member’s experienced/expressed gender and assigned gender, of at least 6 month’s duration, as indicated by two or more of the following:
   1. Marked incongruence between the member’s experienced/expressed gender and primary and/or secondary sex characteristics;
   2. 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;
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender;
   4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender);
   5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender);
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender); AND
B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

II. Eligibility Criteria, meets all
A. Age ≥ 18 years,
   1. Exception: in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment;
B. Capacity to make a fully informed decision and to consent for treatment;
C. If significant medical or mental health concerns present, they must be reasonably well controlled;
D. Evidence the member has lived at least 12 continuous months in a gender role that is congruent with their gender identity;
E. Documentation that member has completed 12 continuous months of cross-sex hormone therapy of the desired gender, unless medically contraindicated (not required for mastectomy in female to male except for those < 18 years);
F. A written referral letter from a qualified mental health practitioner containing all of the following:
   1. Members general identifying characteristics;
   2. Results of psychosocial assessment, including any diagnoses;
   3. Duration of referring health professional’s relationship with the member, including type of evaluation and therapy or counseling to date;
   4. An explanation that criteria for surgery have been met, and a brief description of clinical rationale for supporting the member’s request for surgery;
   5. A statement that informed consent has been obtained from the member;
   6. A statement that the mental health professional is willing and available for coordination of care.
   7. The degree to which the member has followed the standards of care to date and the likelihood of future compliance.
G. If the request is for genital-affirming surgery, a second referral letter from a consulting psychologist or psychiatrist is required.

III. Gender-affirming surgeries considered medically necessary when meeting above criteria
A. Procedures for transwomen (male to female) include:
   • Orchiectomy
   • Penectomy
   • Vaginoplasty
   • Urethroplasty
   • Mammaplasty
   • Clitoroplasty
   • Vulvoplasty
   • Labiaplasty

B. Procedures for transmen (female to male) include:
   • Mastectomy
   • Salpingo-oophorectomy
   • Vaginectomy
   • Vulvectomy
   • Metoidioplasty
   • Phalloplasty
   • Hysterectomy
   • Urethroplasty
   • Scrotoplasty
   • Testicular prosthesis

IV. It is the policy of Health Plans affiliated with Centene Corporation that the following procedures, when used to improve the gender specific appearance of a member undergoing gender affirmation are not medically necessary as they are considered cosmetic in nature (not an all-inclusive list):
   • Abdominoplasty
   • Blepharoplasty
   • Drugs for hair loss or growth
   • Face lift/brow lift
   • Facial implants and bone reconstruction
Hair removal/electrolysis (except for removal of hair on skin graft donor site prior to use in genital reassignment surgery)
- Hair transplantation
- Liposuction
- Mastopexy
- Prosthetic or filler substances to alter contour
- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing
- Thyroid chondroplasty
- Voice modification surgery, therapy or lessons

Background
Gender identity is a person’s deepest inner sense of being female or male, which for many is established by the age of 2 – 3 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. Gender dysphoria refers to the discomfort or distress that is cause 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). Only some transsexual, transgender, and gender-nonconforming people experience gender dysphoria at some point in their lives.

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 if they differ from the sex assigned them at birth.

Guidelines from the World Professional Association for Transgender Health, Inc (WPATH) recommend that genital surgery not be carried out until patients reach the legal age of majority in a given country, and have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention. The guidelines note, however, that chest surgery in female to male patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent’s specific clinical situation and goals for gender identity expression.

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 2019, 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
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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.

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11950-11954</td>
<td>Subcutaneous injection of filling material (eg, collagen)</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>14000</td>
<td>Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less</td>
</tr>
<tr>
<td>14001</td>
<td>Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm</td>
</tr>
<tr>
<td>14040</td>
<td>Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less</td>
</tr>
<tr>
<td>14041</td>
<td>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</td>
</tr>
<tr>
<td>15100</td>
<td>Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)</td>
</tr>
<tr>
<td>15101</td>
<td>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)</td>
</tr>
<tr>
<td>15120</td>
<td>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)</td>
</tr>
<tr>
<td>15121</td>
<td>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)</td>
</tr>
<tr>
<td>15200</td>
<td>Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less</td>
</tr>
<tr>
<td>15570</td>
<td>Formation of direct or tubed pedicle, with or without transfer; trunk</td>
</tr>
<tr>
<td>15574</td>
<td>Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet</td>
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<tr>
<td>15600</td>
<td>Delay of flap or sectioning of flap (division and inset); at trunk</td>
</tr>
<tr>
<td>15620</td>
<td>Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet</td>
</tr>
<tr>
<td>15757</td>
<td>Free skin flap with microvascular anastomosis</td>
</tr>
<tr>
<td>15758</td>
<td>Free fascial flap with microvascular anastomosis</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>CPT® Codes</td>
<td>Description</td>
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<tr>
<td>------------</td>
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</tr>
<tr>
<td>15780-15783</td>
<td>Dermabrasion</td>
</tr>
<tr>
<td>15786</td>
<td>Abrasion; single lesion (eg, keratosis, scar)</td>
</tr>
<tr>
<td>15787</td>
<td>Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)</td>
</tr>
<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>15820-15823</td>
<td>Blepharoplasty</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>15832-15839</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy)</td>
</tr>
<tr>
<td>15876-15879</td>
<td>Suction assisted lipectomy</td>
</tr>
<tr>
<td>17380</td>
<td>Electrolysis epilation, each 30 minutes</td>
</tr>
<tr>
<td>19303</td>
<td>Mastectomy, simple, complete</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>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>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</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>CPT® Codes</td>
<td>Description</td>
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<tr>
<td>------------</td>
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</tr>
<tr>
<td>30400</td>
<td>Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30410</td>
<td>Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30420</td>
<td>Rhinoplasty, primary; including major septal repair</td>
</tr>
<tr>
<td>30430</td>
<td>Rhinoplasty, secondary; minor revision (small amount of nasal tip work)</td>
</tr>
<tr>
<td>30435</td>
<td>Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)</td>
</tr>
<tr>
<td>30450</td>
<td>Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)</td>
</tr>
<tr>
<td>31599</td>
<td>Unlisted procedure, larynx</td>
</tr>
<tr>
<td>31899</td>
<td>Unlisted procedure, trachea, bronchi</td>
</tr>
<tr>
<td>53410</td>
<td>Urethroplasty, 1-stage reconstruction of male anterior urethra</td>
</tr>
<tr>
<td>53415</td>
<td>Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra</td>
</tr>
<tr>
<td>53420</td>
<td>Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage</td>
</tr>
<tr>
<td>53425</td>
<td>Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage</td>
</tr>
<tr>
<td>53430</td>
<td>Urethroplasty reconstruction female urethra</td>
</tr>
<tr>
<td>53460</td>
<td>Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)</td>
</tr>
<tr>
<td>54125</td>
<td>Amputation of penis; complete</td>
</tr>
<tr>
<td>54400</td>
<td>Insertion of penile prosthesis; non-inflatable (semi-rigid)</td>
</tr>
<tr>
<td>54401</td>
<td>Insertion of penile prosthesis; inflatable (self-contained)</td>
</tr>
<tr>
<td>54405</td>
<td>Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir</td>
</tr>
<tr>
<td>54406</td>
<td>Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis</td>
</tr>
<tr>
<td>54408</td>
<td>Repair of component(s) of a multi-component, inflatable penile prosthesis</td>
</tr>
<tr>
<td>54410</td>
<td>Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session</td>
</tr>
<tr>
<td>54411</td>
<td>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</td>
</tr>
<tr>
<td>54415</td>
<td>Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis</td>
</tr>
<tr>
<td>54416</td>
<td>Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session</td>
</tr>
<tr>
<td>54417</td>
<td>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</td>
</tr>
<tr>
<td>54520</td>
<td>Orchiectomy simple with or without testicular prosthesis, scrotal or inguinal approach</td>
</tr>
</tbody>
</table>
## CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54660</td>
<td>Insertion testicular prosthesis (separate procedure)</td>
</tr>
<tr>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy</td>
</tr>
<tr>
<td>55175</td>
<td>Scrotoplasty; simple</td>
</tr>
<tr>
<td>55180</td>
<td>Scrotoplasty; complicated</td>
</tr>
<tr>
<td>55970</td>
<td>Intersex surgery; male to female</td>
</tr>
<tr>
<td>55980</td>
<td>Intersex surgery; female to male</td>
</tr>
<tr>
<td>56625</td>
<td>Vulvectomy simple; complete</td>
</tr>
<tr>
<td>56800</td>
<td>Plastic repair of introitus</td>
</tr>
<tr>
<td>56805</td>
<td>Clitoroplasty intersex state</td>
</tr>
<tr>
<td>56810</td>
<td>Perineoplasty, repair of perineum, nonobstetrical (separate procedure)</td>
</tr>
<tr>
<td>57106</td>
<td>Vaginectomy, partial removal of vaginal wall;</td>
</tr>
<tr>
<td>57107</td>
<td>Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)</td>
</tr>
<tr>
<td>57110</td>
<td>Vaginectomy complete removal vaginal wall</td>
</tr>
<tr>
<td>57111</td>
<td>Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)</td>
</tr>
<tr>
<td>57291</td>
<td>Construction artificial vagina; without graft</td>
</tr>
<tr>
<td>57292</td>
<td>Construction artificial vagina; with graft</td>
</tr>
<tr>
<td>57295</td>
<td>Revision (including removal) of prosthetic vaginal graft; vaginal approach</td>
</tr>
<tr>
<td>57296</td>
<td>Revision (including removal) of prosthetic vaginal graft; open abdominal approach</td>
</tr>
<tr>
<td>57335</td>
<td>Vaginoplasty intersex state</td>
</tr>
<tr>
<td>57426</td>
<td>Revision (including removal) of prosthetic vaginal graft, laparoscopic approach</td>
</tr>
<tr>
<td>58150</td>
<td>Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58263</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele</td>
</tr>
<tr>
<td>58267</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with colpopo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control</td>
</tr>
<tr>
<td>58270</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele</td>
</tr>
<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy</td>
</tr>
<tr>
<td>58285</td>
<td>Vaginal hysterectomy, radical (Schauta type operation)</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58292</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele</td>
</tr>
</tbody>
</table>
### CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>58293</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control</td>
</tr>
<tr>
<td>58294</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele</td>
</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;</td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;</td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58550</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58552</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58553</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58554</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58571</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58572</td>
<td>Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 g</td>
</tr>
<tr>
<td>58573</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58661</td>
<td>Laparoscopy surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)</td>
</tr>
<tr>
<td>58720</td>
<td>Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)</td>
</tr>
<tr>
<td>58940</td>
<td>Oophorectomy, partial or total, unilateral or bilateral</td>
</tr>
<tr>
<td>58999</td>
<td>Unlisted procedure, female genital system (nonobstetrical)</td>
</tr>
<tr>
<td>64856</td>
<td>Suture of major peripheral nerve, arm or leg, except sciatic; including transposition</td>
</tr>
<tr>
<td>64892</td>
<td>Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length</td>
</tr>
<tr>
<td>64896</td>
<td>Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length</td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
</tbody>
</table>

### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

<table>
<thead>
<tr>
<th>ICD 10 CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F64.0 - F64.9</td>
<td>Gender identity disorders</td>
</tr>
<tr>
<td>Z87.890</td>
<td>Personal history of sex reassignment</td>
</tr>
</tbody>
</table>
# Clinical Policy

## Gender-Affirming Surgery

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy developed; specialist reviewed</td>
<td>11/14</td>
<td>11/14</td>
</tr>
<tr>
<td>Criteria II.D changed to ‘Evidence the member lived’ instead of requirement to complete Criteria II.E added note that hormone therapy not required for mastectomy in female to male</td>
<td>11/15</td>
<td>11/15</td>
</tr>
<tr>
<td>Added to II.F: The degree to which the member has followed the standards of care to date and the likelihood of future compliance. Changed mammaplasty to medically necessary for transwomen Updated coding tables</td>
<td>11/16</td>
<td>11/16</td>
</tr>
<tr>
<td>Added to II.A.1: Exception: in adolescent female to male patients &lt; 18 years, chest surgery may be considered after one year of testosterone treatment. Revised II E to reiterate that cross-sex hormone in mastectomy for female to male is required for those &lt; 18 years. Codes reviewed and updated</td>
<td>11/17</td>
<td>11/17</td>
</tr>
<tr>
<td>Added clitoroplasty, vulvoplasty and labiaplasty to section III.A. References reviewed and updated. Codes reviewed and updated.</td>
<td>09/18</td>
<td>10/18</td>
</tr>
<tr>
<td>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.</td>
<td>10/19</td>
<td>10/19</td>
</tr>
<tr>
<td>Removed indication for endometrial ablation as it is included in CP.MP.106.</td>
<td></td>
<td>11/19</td>
</tr>
<tr>
<td>Removed CPT code 19304 - code deleted 1/1/2020</td>
<td>04/20</td>
<td></td>
</tr>
</tbody>
</table>

## References

5. Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. 2011.
7. 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](http://pediatrics.aappublications.org/content/132/1/e297)


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**Note: For Medicare members**, 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.

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