

Clinical Policy: Gender Affirmation Surgery

Reference Number: PA.CP.MP.95

Effective Date: 01/18

Last Review Date: 11/19

[Coding Implications](#)

[Revision Log](#)

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 Affirmation surgery *when such services are included under the members' benefit plan contract provisions.*

Policy/Criteria

It is the policy of Pennsylvania Health and Wellness[®] (PHW) that the Gender Affirmation surgeries listed in section III are considered **medically necessary** for members when diagnosed with gender dysphoria per criteria in section I and when meeting 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

Age \geq 18 years

- A. Capacity to make a fully informed decision and to consent for treatment;
- B. If significant medical or mental health concerns present, they must be reasonably well controlled;
- C. Evidence the member has lived at least 12 continuous months in a gender role that is congruent with their gender identity prior to genital sex confirmation surgery;
- D. 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
- E. A written referral letter from a qualified mental health practitioner *containing all* of the following:

CLINICAL POLICY

Gender Affirming Surgery



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
- F. If the request is for genital confirmation surgery, a second referral letter from a consulting psychologist or psychiatrist is required.

III. Gender Affirmation surgeries considered medically necessary when meeting above criteria:

Mastectomy

Mastectomy, simple, complete

Mastectomy, subcutaneous

Mastopexy

Reduction mammoplasty

Mammoplasty, augmentation; without prosthetic implant

Mammoplasty, augmentation; with prosthetic implant

Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

Nipple/areola reconstruction

Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

Breast reconstruction with free flap

Breast reconstruction with other technique

Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site

Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)

Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site

Periprosthetic capsulectomy, breast

Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

IV. It is the policy of PHW 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). In individuals with severe gender dysphoria, these procedures should be considered on a case by case basis depending on the unique clinical situation of a given patient's condition and life situation:

- Abdominoplasty
- Blepharoplasty
- Drugs for hair loss or growth
- Hair removal/electrolysis (except for the removal of hair on skin graft donor site prior to use in genital reassignment surgery)
- Face lift
- Facial implants and bone reconstruction
- Hair transplantation
- Liposuction
- Prosthetic or filler substances to alter contour
- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing
- Thyroid chondroplasty/Voice modification surgery except Laryngoplasty, cricoid split

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 sex⁵. *Gender dysphoria* refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics^{3, 6}). 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 Affirmation 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.¹¹ 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

CLINICAL POLICY
Gender Affirming Surgery



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.¹¹

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

CPT codes that may be considered part of Gender Affirming surgery.

This code list does not indicate if a procedure is or is not considered medically necessary.

CPT® Codes	Description
11950-11954	Subcutaneous injection of filling material (eg, collagen)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less

CLINICAL POLICY
Gender Affirming Surgery



CPT® Codes	Description
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15600	Delay of flap or sectioning of flap (division and inset); at trunk
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780-15783	Dermabrasion
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820-15823	Blepharoplasty
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832-15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876-15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19316	Mastopexy
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)

CLINICAL POLICY
Gender Affirming Surgery



CPT® Codes	Description
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty reconstruction female urethra
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

CLINICAL POLICY
Gender Affirming Surgery



CPT® Codes	Description
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy simple with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall;
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy complete removal vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction artificial vagina; without graft
57292	Construction artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele

CLINICAL POLICY
Gender Affirming Surgery



CPT® Codes	Description
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58293	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral
58999	Unlisted procedure, female genital system (nonobstetrical)
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length

CLINICAL POLICY
Gender Affirming Surgery



CPT® Codes	Description
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F64.0 - F64.9	Gender identity disorders
Z87.890	Personal history of sex reassignment

Reviews, Revisions, and Approvals	Date	Approval Date
Added clitoroplasty, vulvoplasty and labiaplasty to section III.A. References reviewed and updated. Codes reviewed and updated.	10/18	
Codes reviewed and updated.	08/19	
Replaced term “gender reassignment” with “gender affirmation” throughout the policy and changed title to “Gender Affirming Procedures”. Added criteria for endometrial ablation as a medically necessary procedure for transmen. Added as not medically necessary brow lift and voice therapy/lessons. Codes reviewed (14040 corrected and 14001 and 15101 added, along with various description updates). Reviewed by specialist.	11/19	

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CLINICAL POLICY

Gender Affirming Surgery



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