



Gender Affirming Surgery and Related Procedures

LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid	State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Oregon <input type="checkbox"/> Washington
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Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Gender affirming surgery and related procedures are treatments that a health care provider prescribes to an individual to treat the incongruence between the individual's gender identity and their sex assignment at birth, or to support and affirm the individual's gender identity. Gender affirming treatment can be prescribed to transgender, nonbinary, two spirit, and other gender diverse individuals. These treatments may be a covered benefit for members with diagnoses of F64.0 through F64.9 (gender identity and dysphoria disorders), or Z87.890, personal history of sex reassignment.

PacificSource reviews for coverage in accordance with benefit plan language and established medical criteria. Some PacificSource benefit plans do not include coverage of all gender affirming surgeries and related procedures. Groups may elect to customize benefits; therefore, some benefit determinations may be based on contract language.

PacificSource uses the following criteria for all requests for gender affirming surgery. The gender affirming surgery and related procedures criteria is in alignment with Oregon House Bill 2002 and Guideline Note 127 of the Oregon Health Plan Prioritized List of Health Services.

PacificSource Medicare follows CMS guidelines and criteria. National Coverage Determination (NCD) 140.9 and Local Coverage Determination (LCD) L35163 do not outline specific criteria and give direction for a case-by-case review. In absence of CMS criteria, PacificSource Medicare requests are

reviewed on an individual basis for determination of coverage and medical necessity using this policy criteria.

Care Management services are available for members to assist with understanding benefits and criteria related to gender affirming surgery and treatment, and to provide support navigating gender affirming health care.

Criteria

The following coverage and criteria are based on the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 8.

Commercial, Medicaid and Medicare

I. Gender Affirming Treatment Coverage

A. Core Gender Affirming

PacificSource may cover the following procedures:

- Clitoroplasty
- Breast reconstruction/augmentation/mammaplasty with fat transfer/graft or implants
- Body Contouring, only including liposuction, lipofilling, and implants
 - Gender affirming body contouring must target areas that affect gender presentation
 - Requests that include skin excision are reviewed on a case-by-case basis and must include documentation from the provider noting how the skin-excision is medically necessary to treat the individual's gender dysphoria.
- Hair removal (electrolysis or laser) for gender affirmation or as required pre-operatively on the surgical site or skin graft site
- Hysterectomy
- Labiaplasty
- Mastectomy, which may include nipple reconstruction, targeted nipple-areolar complex reinnervation, nerve coaptation, tattooing, or liposuction
- Metoidioplasty/Meta
- Monsplasty/mons reduction
- Orchiectomy
- Penectomy
- Phalloplasty, which may include penile implant, nerve coaptation, and skin substitutes
- Placement of testicular implant
- Salpingo-oophorectomy
- Scrotoplasty
- Urethroplasty
- Vaginectomy

- Vaginoplasty
- Vulvoplasty

B. Facial Gender Affirming

PacificSource may cover the following procedures:

- Blepharoplasty
- Brow reduction, augmentation, and lift
- Cheek/Malar augmentation, including reshaping, fat transfer/grafting (which may include liposuction and lipofilling), and implants.
- Chin reconstruction/genioplasty
- Facelift/mid-face lift/rhytidectomy (following alteration of the underlying skeletal structures), including platysmaplasty (neck tightening)
- Forehead lift
- Frontal bone reshaping/reduction
- Hair line advancement and/or hair transplant
- Hair removal (electrolysis or laser)
- Jaw (mandible) bone reshaping
- Laryngoplasty or laryngectomy (vocal cord surgery)
- Lip, which includes upper lip shortening, lip augmentation (includes fat transfer, lip implants, injectable fillers)
 - Requests for authorization of non-permanent injectable fillers must include assessment from a surgeon noting medical necessity of treatment and individualized treatment plan to address gender dysphoria
- Lipofilling
- Rhinoplasty (+/- fillers)
 - Requests for authorization of non-permanent injectable fillers must include assessment from a surgeon noting medical necessity of treatment and individualized treatment plan to address gender dysphoria
- Tracheal shave/chondrolaryngoplasty

C. Voice and Communication Therapy

PacificSource covers gender affirming voice and communication therapy within traditional therapies (PT/ST/OT) benefits. See the member benefit book for specific contract for therapy benefit coverage and limitations.

D. Revisions

PacificSource covers revisions of previous gender affirming surgeries that are medically necessary and prescribed in accordance with WPATH standards of care. Request must include surgical pre-

exam or consultation clinical notes and the clinical rationale for supporting the requested surgical procedures.

Note: See member benefit handbook for specific scar revision contract exclusions.

E. Reversal

PacificSource does not cover reversal of a gender affirming surgery.

G. Adverse Benefit Determinations (Non-coverage)

All potential adverse benefit determinations (non-approvals) are reviewed and determined by a health care provider with experience prescribing or delivering gender affirming treatment.

II. Hormone Therapy

PacificSource Pharmacy Department reviews requests for hormone therapy for members under eighteen (18) years of age.

Prior authorization is not required for gender affirming hormone therapies for members 18 years of age and older.

III. Gender Affirming Surgery

A. Gender Affirming Surgical Procedures and Hair Removal for Adults

Prior authorization is required.

PacificSource considers gender affirming surgical procedures (includes procedures listed in section I, A and B above), and hair removal (electrolysis or laser), medically necessary when **ALL** of the following criteria is met:

1. **One** letter of support is included with the prior authorization request, written by a qualified, licensed health care professional who has experience in the assessment of transgender and gender diverse individuals. Qualified Mental Health Provider (QMHP) and non-licensed professional letters are not eligible without licensed supervising provider's co-signature. The referring licensed health care professional's letter must be written within **2 years** of the prior authorization request and include **ALL** of the following :
 - a. Member is at least 18 years old
 - b. Member has a diagnosis of gender dysphoria
 - c. Member's identifying characteristics and that their gender incongruence is marked and sustained
 - d. Member demonstrates capacity consent for treatment
 - e. Member understands the effect of gender-affirming surgery on reproduction and reproductive options have been explored. This can be addressed by any provider on the member's care team, including the surgeon
 - f. Other possible causes of apparent gender-incongruence have been identified and excluded
 - g. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgery have been assessed, with risks and benefits discussed

- h. Member is stable on their hormone treatment, which may include 6 months of treatment, or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated.
- 2. Request must include individualized treatment plan, pre-exam or consultation notes, and clinical rationale for supporting the requested procedures. Clinical notes should also show evidence the member has been counseled on potential risks of treatment, complications, and post-surgical recovery and long-term care. Requests for hair removal must include treatment plan/areas of focus of treatment.

B. Gender Affirming Surgical Procedures and Hair Removal for Adolescents

Prior authorization is required.

All gender affirming surgical treatment for adolescents requires MD review.

PacificSource considers gender affirming surgery, including hair removal (electrolysis or laser), medically necessary when **ALL** of the following criteria is met:

- 1. Member has received a comprehensive biopsychosocial assessment including relevant mental health and medical professionals. This includes parent(s)/guardian(s) involvement in the assessment process unless the involvement is determined to be harmful to the adolescent or not feasible.
- 2. **One** letter of support is included with the prior authorization request written by a qualified, licensed health care professional who has experience in the evaluation transgender and gender diverse youth. Qualified Mental Health Provider (QMHP) and non-licensed professional letters are not eligible without licensed supervising provider's co-signature. The referring licensed health care professional's letter must be written within **12 months** of the authorization request and include **ALL** of the following:
 - a. The letter must reflect the comprehensive assessment and opinion from the treatment team that involves both medical and mental health professions
 - b. Member has a diagnosis of gender dysphoria
 - c. Member's identifying characteristics and that their gender diversity/incongruence is marked and sustained over time.
 - d. Member demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment
 - e. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender affirming medical treatment have been addressed; sufficiently so that gender affirming medical treatment can be provided optimally
 - f. Member has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility. This can be addressed by any provider on the member's care team.
 - g. Member has had at least 12 months of gender affirming hormone therapy or longer, if required, to achieve the desired surgical result for the procedures, unless hormone therapy is either not desired or is medically contraindicated
- 3. Request must include individualized treatment plan, pre-exam or consultation notes, and clinical rationale for supporting the requested surgical procedures. Clinical notes should also show

evidence the member has been counseled on potential risks of treatment, complications, and post-surgical recovery and long-term care.

Experimental/Investigational/Unproven

PacificSource considers nerve coaptation for gender-affirming mastectomy or phalloplasty using a synthetic conduit or vein allograft to be experimental, investigational, or unproven.

Definitions

Blepharoplasty - Surgery to modify the eyelid.

Clitoroplasty - Surgery to create a clitoris.

Electrolysis- A hair removal treatment that uses an electrical current to destroy hair follicles and remove hair

Gender Dysphoria - A marked incongruence between one's own experienced/expressed gender and assigned gender.

Genioplasty - Surgery to alter the chin.

Hysterectomy - Surgery to remove all or part of the uterus.

Labiaplasty - Surgery to alter the labia.

Laryngoplasty or laryngectomy - Surgery on the larynx (voice box) to alter one's voice.

Laser Hair Removal – A procedure that uses concentrated beam of light to reduce and remove hair

Lipofilling – Surgical transfer of fat removed by liposuction to other areas of the body

Mammoplasty - Surgery to reconstruct or alter the breast.

Mastectomy - Surgery to remove one or both breasts.

Metoidioplasty - Surgery that works with existing genital tissue of individuals assigned female at birth to form a neophallus, or "new penis."

Monsplasty – Surgery to remove extra skin and tissue from the mons pubis, which is the mound of tissue in front of the pubic bone.

Orchiectomy - Surgery to remove of one or both testicles.

Platysmaplasty- Surgery to tighten skin on the neck.

Penectomy - Surgery to removal the penis.

Phalloplasty - Surgical procedures to construct a penis.

Rhinoplasty - Surgery that changes the shape of the nose.

Rhytidectomy - Surgical face lift.

Salpingo-oophorectomy - Surgery to remove one or both ovaries and fallopian tubes.

Scrotoplasty - Surgery that creates a scrotum.

Tracheal Shave/Chondrolaryngoplasty - Surgery to reduce the size of the Adam's apple.

Urethroplasty - Plastic surgery of the urethra.

Vaginectomy - Surgery to remove all or part of the vagina.

Vaginoplasty - Surgery to create a vagina.

Vulvoplasty - Surgery to create a vulva

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

The following CPT codes may be covered when the above criteria is met:

11920- Tattooing To Correct Color Defects

11922

11950- Subcutaneous injection of filling material (e.g., collagen)

11954

13131- Repair, Complex, Forehead/Cheeks/Chin/Mouth/Neck/Axillae/Genitalia/Hands/Feet;

13133

14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

14061 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm

14301 Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm

14302 Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

15273 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

15274 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

15769 Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)

15770 Graft; derma-fat-fascia

15771- Grafting of autologous fat harvested by liposuction technique

15774

15775- Punch graft for hair transplant;

15776

15820- Blepharoplasty
15823

15824- Rhytidectomy (face-lift)
15829

15830- Excision, excessive skin, and subcutaneous tissue (includes lipectomy, neck
15839 tightening); abdomen, infraumbilical panniculectomy

15876- Suction assisted lipectomy
15879

17110 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical
curettement), of benign lesions other than skin tags or cutaneous vascular proliferative
lesions; up to 14 lesions

17111 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical
curettement), of benign lesions other than skin tags or cutaneous vascular proliferative
lesions; 15 or more lesions

17380 Electrolysis epilation, each 30 minutes

17999 Unlisted procedure, Skin, mucous membrane

19303 Mastectomy, simple, complete

19318 Breast reduction

19325 Breast augmentation with implant

19350 Nipple/areola reconstruction

20912 Cartilage graft; nasal septum

21025 Excision of bone (e.g., for osteomyelitis or bone abscess); mandible

21026 Excision of bone (e.g., for osteomyelitis or bone abscess); facial bone(s)

21120- Genioplasty
21123

21125 Augmentation, mandibular body, or angle; prosthetic material

21127 Augmentation, mandibular body, or angle; with bone graft, onlay or interpositional (includes
obtaining autograft)

21137- Frontal Bone reshaping (forehead reduction and contouring)
21139

21141- Reconstruction Midface, Lefort W/O Bone Graft
21143

21145- Reconstruction Midface, Lefort, W/ Bone Graft
21147

21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement, or alteration,
with or without grafts (includes obtaining autografts)

- 21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement, or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
- 21188 Reconstruction, Midface, Osteotomies (Non-Lefort Type), W/Grafts, W/Obtaining Autografts
- 21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
- 21208 Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
- 21209 Osteoplasty, facial bones; reduction
- 21235 Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
- 21270 Malar augmentation, prosthetic material
- 21295 Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
- 30400- Rhinoplasty; primary
- 30420
- 30430- Rhinoplasty; secondary
- 30450
- 30465 Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
- 30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft
- 31599 Unlisted procedure, larynx
- 31750 Tracheoplasty; cervical
- 31899 Unlisted procedure, trachea, bronchi (tracheal shaving for gender facial confirmation)
- 40654 Repair lip, full thickness; over one-half vertical height, or complex
- 40799 Unlisted procedure, lips
- 51102 Aspiration of bladder; with insertion of suprapubic catheter
- 52281 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
- 53010 Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
- 53020 Meatotomy, cutting of meatus (separate procedure); except infant
- 53400- Urethroplasty
- 53430
- 53450 Urethromeatoplasty, with mucosal advancement
- 53520 Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)
- 54120 Amputation of penis; partial
- 54125 Amputation of penis; complete
- 54348 Repair, hypospadias complication(s) (i.e., fistula, stricture, diverticula); requiring extensive dissection, urethroplasty with flap, patch, or tubed graft (including urinary diversion, when performed)

54352 Revision prior hypospadias repair requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin grafts and island flaps and skin brought in as flaps or grafts

54360 Plastic operation on penis to correct angulation

54400- Penile prosthesis
54417

54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach

54530 Orchiectomy, radical, for tumor; inguinal approach

54660 Insertion of testicular prosthesis (separate procedure)

54690 Laparoscopic, surgical; orchiectomy

55175 Scrotoplasty; simple

55180 Scrotoplasty; complicated

55899 Unlisted surgery of the male genital system (for metoidioplasty and phalloplasty)

55970 Intersex surgery; male to female

55980 Intersex surgery; female to male

56620 Vulvectomy Simple; Partial

56625 Vulvectomy simple; complete

56805 Clitoroplasty for intersex state

56810 Perineoplasty, repair of perineum, nonobstetrical (separate procedure)

57106- Vaginectomy
57107;
57110-
57111

57120 Colpocleisis (Le Fort Type)

57291- Construction of artificial vagina
57292

57335 Vaginoplasty, intersex state

57425 Laparoscopy, surgical, colpopexy (suspension of vaginal apex)

58150, Hysterectomy
58152,
58180,
58260,
58262,
58263
58267
58270
58275-
58291,
58541-
58544,

58550-
58554

58570- Laparoscopy, surgical, with total hysterectomy
58573

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)

58999 Unlisted Proc, Female Genital System (Nonobstetrical)

64905 Nerve pedicle transfer; first stage

64910 Nerve repair; with synthetic conduit or vein allograft (e.g., nerve tube), each nerve

64911 Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve

67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder;
individual

92508 Treatment of speech, language, voice, communication, and/or auditory processing disorder;
group, two or more individuals

The following CPT codes are considered not coverable as part of gender affirming procedures:

15780- Dermabrasion
15787

15788- Chemical Peel
15789

S2900 Surgical techniques requiring use of robotic surgical system

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Related Policies

Care of the Surgical Patient

Coding Guidelines for Claims Editing (Line-Item Bill Auditing)

Skin and Soft Tissue Substitutes

References

American College of Obstetricians and Gynecologists (ACOG). (March 2021). Health Care for Transgender and Gender Diverse Individuals: Committee Opinion, Number 823. Accessed March 16, 2022. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>

American Psychiatric Association. (2013) *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*.

The World Professional Association for Transgender Health (WPATH) (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. <http://www.wpath.org>

Appendix

Policy Number:

Effective: 4/16/2020

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Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): Oregon Guideline Note 127, Oregon House Bill 2002, Washington Senate Bill 5313

Commercial OPs: 6/2025

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