



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, benefit determinations are 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 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/mammoplasty (with fat transfer/graft or implants)
- Body Contouring, including liposuction, lipofilling, and implants
- Hair removal (electrolysis or laser) for gender affirmation or as required pre-operatively on the surgical site or skin graft site
- Hysterectomy
- Labiaplasty
- Mastectomy including nipple reconstruction and tattooing
- Metoidioplasty/ Meta
- Monsplasty/mons reduction
- Orchiectomy
- Penectomy
- Phalloplasty (may include penile implant)
- 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- reshaping, fat transfer/grafting (which may include liposuction), 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
- Lip- upper lip shortening, lip augmentation (includes fat transfer, lip implants, injectable fillers)
- Lipofilling
- Rhinoplasty (+/- fillers)
- Tracheal shave/chondrolaryngoplasty

C. Voice and Communication Therapy

PacificSource covers gender affirming voice and communication therapy within traditional therapies (PT/ST/OT) benefits.

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

1. A letter of recommendation (opinion) must be written within 18 months of the prior authorization request, by **one** qualified, licensed health care professional who has experience in the evaluation of gender dysphoria. Qualified Mental Health Provider (QMHP) letters are not eligible without licensed supervising provider's co-signature. The referring licensed health care professional's letter must include the clinical rationale for supporting the gender-affirming surgical procedure and address **ALL** of the following:
 - a. Member is at least 18 years old
 - b. Member has a diagnosis of gender dysphoria
 - c. Duration of the referring health professional's relationship with the client, including the type of evaluation and treatment
 - d. Member's identifying characteristics and that their gender incongruence is marked and sustained
 - e. Member demonstrates capacity consent for treatment
 - f. 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
 - g. Other possible causes of apparent gender-incongruence have been identified and excluded
 - h. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgery have been assessed, with risks and benefits discussed
 - i. Member has received at least 6 months of hormone treatment, or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated
 - j. Noted permission to contact the licensed health care professional for questions and coordination of care
2. Request must include surgical pre-exam or consultation clinical notes, the clinical rationale for supporting the requested surgical procedures, and a statement that the member meets eligibility criteria. 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.

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. A letter of recommendation (opinion) must be written within 12 months of the prior authorization request for by **one** qualified, licensed health care professional who has experience in the evaluation of gender dysphoria with. Qualified Mental Health Provider (QMHP) letters are not eligible without licensed supervising provider's co-signature. The referring licensed health care professional's letter must include the clinical rationale for supporting the gender-affirming surgical procedure and address **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. Duration of the referring health professional's relationship with the client, including the type of evaluation and treatment
 - d. Member's identifying characteristics and that their gender diversity/incongruence is marked and sustained over time.
 - e. Member demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment
 - f. 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
 - g. 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
 - h. 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
 - i. Noted permission to contact the licensed health care professional for questions and coordination of care
3. Request must include surgical pre-exam or consultation clinical notes, the clinical rationale for supporting the requested surgical procedures, and a statement that the member meets eligibility criteria. 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.

IV. Voice Therapy

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

Definitions

Blepharoplasty - Surgery to modify the eyelid.

Clitoroplasty - Surgery to create a clitoris.

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.

Labioplasty - Surgery to alter the labia.

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

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.

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 - Surgery to reduce the size of the Adam's apple.

Urethroplasty - Plastic surgery of the urethra.

Vaginectomy - Surgery to remove all of 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
- 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)
- 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 (laser hair covered pre-operatively for gender affirming surgery or for facial gender confirmation only)

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
- 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)
- 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 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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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

Related Policies

Care of the Surgical Patient

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

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

Commercial OPs: 4/2024

Government OPs: 4/2024