Clinical Policy: Gender-Affirming Procedures

Reference Number: LA.CP.MP.95c
Date of Last Revision: 09/23~~12/22~~

Coding Implications
Revision Log

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 member/enrollee' benefit plan contract provisions.*

Policy/Criteria

It is the policy of Louisiana Healthcare Connections that the gender-affirming surgeries listed in section III are considered **medically necessary** for member/enrollee 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/enrollee'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/enrollee'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.

Note: Individuals with a disorder of sexual development (i.e. intersex) and gender dysphoria are not required to meet the following criteria:

A. Duration of gender dysphoria;
B. Age requirements;
C. Duration of prior treatment such as hormone therapy.

II. Eligibility Criteria, meets all

~~A.~~ Age ≥ 18 years,

~~1.~~A. ~~Exception: in adolescents with a female reproductive system < 18 years, chest surgery may be considered after one year of testosterone treatment;WITH GUARDIAN CONSENT~~

B. Capacity to make a fully informed decision and to consent for treatment; (including, but not limited to, awareness of the potential effects of treatment on fertility) and to consent for treatment;
C. If significant medical or mental health concerns present, they must be reasonably well controlled;
D. Evidence the member/enrollee has lived at least 12 continuous months in a gender role that is congruent with their gender identity;
E. Documentation that member/enrollee has completed 12 continuous months of cross-sex hormone therapy of the desired gender, unless medically contraindicated; ~~(not required for mastectomy in those with a female reproductive system; to be considered on a case-by-case basis for those < 18 years);~~
F. A written referral letter from a qualified mental health practitioner (minimum of a master's degree or equivalent in a clinical behavioral science field granted by an accredited institution, with documented credentials from a relevant licensing board or equivalent) (independent from the surgery group) *containing all* of the following:
    1. Member/enrollee general identifying characteristics;
    2. Results of psychosocial assessment, including any diagnoses;
    3. Duration of referring health professional's relationship with the member/enrollee, 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/enrollee's request for surgery;
    5. A statement that informed consent has been obtained from the member/enrollee;
    6. A statement that the mental health professional is willing and available for coordination of care.
    7. The degree to which the member/enrollee 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 another qualified mental health professional (indendent from the surgery group)(minimum of a master's degree or equivalent in a clinical behavioral science field granted by an accredited institution, with documented credentials from a relevant licensing board or equivalent), who has independently assessed the member/enrollee is required.

** note: please refer to the requirements of the Qualified Mental Health Professional under the Background section below.

III. Gender-affirming surgeries considered **medically necessary** when meeting above criteria

A. Procedures those with a male reproductive system for include:
- Orchiectomy
- Penectomy
- Vaginoplasty
- Urethroplasty
- Mammaplasty
- Clitoroplasty
- Vulvoplasty
- Labiaplasty

B. Procedures those with a female reproductive system for include:

- Mastectom
- Salpingo-oophorectomy
- Vaginectomy
- Vulvectomy
- Metoidoplasty
- Phalloplasty
- Hysterectomy
- Urethroplasty
- Scrotoplasty
- Testicular prosthesis

IV. It is the policy of Louisiana Healthcare Connections that revision procedures for affirming gender are **medically necessary** when the revision is required to address complications of a prior gender affirming procedure (wound dehiscence, fistula, chronic pain directly related to the surgery, etc.).

V. It is the policy of Louisiana Healthcare Connections that gender affirming facial procedures will be considered for **medical necessity** on a case-by-case basis when meeting the following:

A. Criteria in sections I and II;

B. Requested procedure intends to correct existing facial appearance that demonstrates significant variation from normal appearance for the experienced gender. Possible procedures include, but are not limited to, the following:

1. Blepharoplasty;
2. Face lift/brow lift;
3. Facial implants and bone reconstruction;
4. Hair removal/electrolysis;
5. Drugs for hair loss or growth;
6. Hair transplantation;
7. Prosthetic or filler substances to alter contour;
8. Rhinoplasty;
9. Thyroid chondroplasty;
10. Removal of redundant skin

VI. It is the policy of Louisiana Healthcare Connections that the following procedures, when used to improve the gender specific appearance of a member/enrollee 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
- Prosthetic or filler substances to alter contour
- Rhinoplasty
- Skin resurfacing
- Removal of redundant skin
- Mastopexy
- Thyroid chondroplasty
- Voice modification surgery, therapy or lessons;
- Revision procedures for purposes other than correction of complications

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.[5] *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)[3,6].

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.[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 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]~~

For referral letters, characteristics of a Qualified Mental Health Professional include all of the following:

1. Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national or regional accrediting board. The professional should have documented credentials from a relevant licensing board or equivalent;
2. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Diseases for diagnostic purposes.
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

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 20222~~19~~, 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 and may not support medical necessity. 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
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent implant
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
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

CPT® Codes	Description
15758	Free fascial flap with microvascular anastomosis
15820-15823	Blepharoplasty
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832-15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876-15879	Suction assisted lipectomy
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with 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)
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

CPT® Codes	Description
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
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
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

CPT® Codes	Description
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
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
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

CPT® Codes	Description
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
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	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Added characteristics of a mental health provider to II.F and II.G. Revised criteria in II.G to allow second referral letter from a qualified mental health provider, rather than limiting to psychologist or psychiatrist. References reviewed and updated. Description of CPT 11970, 19325 revised in 2021. CPT 19324, 58293 deleted in 2021. Replaced "member" with "member/enrollee." Added "and may not support medical necessity" to coding implications. Added 19318 to the list of CPT codes that may be considered part of gender affirming procedures.	2/22	4/10/22
Annual Review. Changed "Last Review Date" to "Date of Last Revision" in the header. Added note before the criteria section stating that individuals with a disorder of sexual development (i.e. intersex) don't need to meet all the same criteria for duration of gender dysphoria, age requirements and duration of prior treatment such as hormone therapy. Incorporated gender-neutral language to the eligibility and criteria section II. A. 1, E. and III. A and B. In II.B., noted that informed consent includes awareness of treatment effects on fertility. Added the word "minimum" to degree requirement in criteria II.F. and G. In II.E, noted that the requirement of 12 months of hormone therapy before mastectomy in adolescents should be considered on a case-by-case basis. Added new criteria in section V regarding facial procedures, and modified the not medically necessary procedures list in VI	12/22	2/14/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date
accordingly. Grammatical changes made to the background with no impact to the policy. "Date" changed to "Revision Date" in the revision log header. References reviewed and updated. Specialist reviewed.		
Removed section II. A. 1., Removed "(not required for mastectomy in those with a female reproductive system; to be considered on a case-by-case basis for those < 18 years)" from section II. E., Updated Background with no changes to criteria.	9/23	

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the

effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of member/enrollee. This clinical policy is not intended to recommend treatment for member/enrollee. Member/enrollee should consult with their treating physician in connection with diagnosis and treatment decisions.

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