Regence

Medical Policy Manual Medicine, Policy No. 153

Gender Affirming Interventions for Gender Dysphoria

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IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

This policy addresses interventions for gender dysphoria, a marked incongruence between one's experienced/expressed gender and assigned gender.

MEDICAL POLICY CRITERIA

Notes:

- Member contracts for covered services vary. Member contract language takes precedence over medical policy.
- The Washington Gender Affirming Treatment Act (SSB 5313; https://legiscan.com/WA/bill/SB5313/2021) addresses coverage for gender affirming treatment for relevant member contracts.
- The Oregon Reproductive Health Rights Act (HB 2002; https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2002 addresses coverage for gender affirming treatment for relevant member contracts.
- This policy does not address the following interventions:

- Psychotherapy, which may be considered medically necessary for gender dysphoria; and
- Medications such as hormonal therapy (see Cross References).

I. Gender affirming interventions for gender dysphoria may be considered **medically necessary** when either of the following criteria is met:

A. For *member contracts subject to Washington's Gender Affirming Treatment Act* (SSB 5313) or *Oregon Reproductive Health Rights (HB 2002)*, all of the following criteria are met (1. –6.):

1. Documentation that a licensed health care professional or licensed mental health professional with experience in the assessment and treatment of gender dysphoria (see Policy Guidelines) has established the medical necessity of the requested intervention for gender-affirming care (including documentation of the suitability of the patient for the intervention and agreement with the treatment plan); and
2. A documented diagnosis (see Policy Guidelines) of gender dysphoria by a licensed mental health professional (see Policy Guidelines); and
3. Six continuous months of hormone therapy, in the immediately preceding 12 months, as appropriate to the patient's gender goals unless hormones are not clinically indicated for the individual (Notes: hormonal therapy is not required prior to breast/chest surgery); and
4. At least 6 months of living in a role that is congruent with the patient's identity; and
5. The request is for treatment(s) as prescribed (see Policy Guidelines) by the treating provider because of, related to, or consistent with a person's gender expression or identity and is prescribed in accordance with accepted standards of care; and
6. Either of the following is met:
    a. Age at least 18 years; or
    b. Request is not for genital surgery and documentation is provided that earlier intervention is medically necessary and that the individual demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment. Provider must be a mental health provider who specializes in adolescent transgender care.

B. For *all other member contracts*, both of the following criteria are met (1. – 2.):

1. All of following general criteria are met (a. – f.):
    a. Age at least 18 years (Note: age requirement will not be applied to breast/chest surgery with documentation that earlier intervention is medically necessary and that the individual demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment. Documentation must be from a mental health provider who specializes in adolescent transgender care.); and

b. Documentation that a licensed health care professional or licensed mental health professional with experience in the assessment and treatment of gender dysphoria (see Policy Guidelines) has established the medical necessity of the requested intervention for gender-affirming care (including documentation of the suitability of the patient for the intervention and agreement with the treatment plan); and

c. A documented diagnosis (see Policy Guidelines) of gender dysphoria by a licensed mental health professional (see Policy Guidelines); and

d. Six continuous months of hormone therapy, in the immediately preceding 12 months, as appropriate to the patient's gender goals unless hormones are not clinically indicated for the individual (Note: hormonal therapy is not required prior to breast/chest surgery); and

e. At least 6 months of living in a role that is congruent with the patient's identity; and

f. The requested procedure is specific to the primary and/or secondary sex characteristics of some alternative gender different from one's assigned gender and would not be pursued for other reasons, e.g., to improve appearance or to correct medical or surgical problems unrelated to feminization, masculinization, or non-binary transition.

2. One or more of the following criteria are met:

   a. The request is for any of the following procedures:

      i. Clitoroplasty

      ii. Hysterectomy (Note: Hysterectomy is considered medically necessary without routine review and is not required to meet Criterion I.B.1.)

      iii. Labiaplasty

      iv. Breast/chest surgery (i.e., breast augmentation, breast reduction, mastectomy, mastopexy, nipple/areola reconstruction/repositioning, nipple tattoo)

      v. Metoidioplasty

      vi. Orchiectomy

      vii. Penectomy

      viii. Penile prostheses implantation

      ix. Phallic reconstruction/Phalloplasty

      x. Salpingo-oophorectomy

      xi. Scrotoplasty

      xii. Testicular prostheses implantation

      xiii. Urethroplasty

      xiv. Vaginectomy

      xv. Vaginoplasty

b. Clinical documentation is submitted expressly documenting that the intervention would improve otherwise documented significant gender dysphoria and the request is for one or more of the following procedures:

i. Hair removal

ii. Hair transplantation

iii. Facial gender confirmation surgery when the purpose of the surgery is to be publicly identified as gender congruent and not to improve appearance for any of the following procedures (see Required Documentation):

a.) Hairline advancement/brow lift

b.) Forehead contouring/frontal sinus setback

c.) Implants (cheek/malar, frontal, mandible, or chin) when used in facial masculinization

d.) Canthoplasty

e.) Rhinoplasty/Rhinoseptoplasty

f.) Lip lift/lip fat grafting

g.) Mandible (jaw) bone reshaping/Mandibular angle and body contouring

h.) Genioplasty

i.) Tracheal shave

j.) Face lift (rhytidectomy) or liposuction (only as needed in conjunction with one of the above procedures).

iv. Voice modification surgery

v. Endometrial ablation when **all** of the following criteria are met:

a.) Hysteroscopy, sonohysterography (SIS), or pelvic ultrasound has been performed and report is provided; and

b.) Endometrial sampling or dilation and curettage (D&C) has been performed or is planned according to any of the following:

i.) Endometrial sampling or D&C has been performed and report is provided. The histopathology report is provided showing absence of endometrial hyperplasia or uterine cancer; or

ii.) Endometrial sampling or D&C has been performed and report is provided. The histopathology report is provided, but inadequate tissue was obtained for diagnosis; or

iii.) Cervical stenosis precludes endometrial sampling, and D&C is planned concomitantly with ablation procedure.

II. Gender affirming surgical interventions for gender dysphoria are considered **not medically necessary** for gender dysphoria when either of the following is met:

A. For member contracts subject to *Washington's Gender Affirming Treatment Act* (SSB 5313) or *Oregon Reproductive Health Rights (HB 2002)*, when Criterion I.A. is not met; or

B. For member contracts ***not*** subject to Washington's Gender Affirming Treatment Act (SSB 5313) or *Oregon Reproductive Health Rights (HB 2002)*, when any of the following is met:

1. Interventions listed in Criterion I.B.2 that do not meet the medical necessity criteria listed in Criterion I.B.1.; or
2. Interventions not listed in Criterion I.B.2. including, but not limited to abdominoplasty, blepharoplasty, calf implants, nose implants, collagen injections, neck tightening, panniculectomy, pectoral implants, suction-assisted lipoplasty of the waist, revision to a previous gender affirming surgery because of dissatisfaction with the appearance; or
3. Procedures intended solely to reduce the appearance of aging that will not result in significant improvement of the condition being treated; or
4. Reversal of gender affirming interventions.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

Some procedures that do not require a prescription (e.g., hair removal or nipple tattooing) may be considered prescribed based on the referral for the procedure from a licensed mental health professional.

LICENSED MENTAL HEALTH PROFESSIONAL (MHP)

- State licensed to practice independently (without supervision) as master's degree level mental health clinicians, doctoral level mental health clinicians, psychiatric nurse practitioners, psychiatric physician assistants, or Board-Eligible or Board-Certified psychiatrists.
- Statutorily regulated mental health professionals with lower levels of qualification under the clinical supervision of a qualified MHP who takes ultimate clinical responsibility for the quality and accuracy of the completed assessment.

LICENSED HEALTH CARE PROFESSIONALS (HCP)

- State licensed to practice independently (without supervision) as master's degree level or equivalent (doctoral level clinicians, nurse practitioners, physician assistants, or Board-Eligible or Board-Certified psychiatrists).
- Experienced in the assessment and treatment of gender dysphoria and providing gender-affirming care.

DOCUMENTED DIAGNOSIS

Documentation from a licensed mental health professional must include confirmation that they have directly assessed the member and verified that the member has a current diagnosis of gender dysphoria

FACIAL PROCEDURES

Below are some different terms for the procedures listed in the Policy Criteria:

- Tracheal shave may be known as thyroid chondroplasty, chondrolaryngoplasty, or thyroid cartilage reduction, Adam's apple contouring
- Chin reconstruction may include genioplasty, chin contouring
- Mandible (jaw) bone reshaping may include mandibular angle and body contouring

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact the review and decision outcome:

- History and Physical/Chart Notes
    - Documentation of therapy requested if applicable
    - Documentation of patient capacity to make decisions/consent to treatment
- For medical treatment or mastectomy:
    - Documentation that a licensed mental health professional has diagnosed gender dysphoria
    - Documentation of length of time living as desired gender
    - Documentation of length of time therapy occurred including licensure of therapist
    - For patients under the age of 18, documented provider determination of medical necessity of earlier intervention
- For all surgical treatments:
    - Documentation that at least one licensed mental health professional has diagnosed gender dysphoria
    - Documentation that a licensed health care professional or mental health professional with experience assessing and treating gender dysphoria has recommended the surgical treatment. Documentation to demonstrate experience assessing and treating gender dysphoria may include the following: WPATH certification or a statement of experience (e.g., a letter, or note in the clinical chart)
- For all surgical treatments, excluding breast/chest surgery:
    - Documentation of continuous hormone therapy for at least six months in the 12 months immediately preceding the surgical procedure unless contraindicated.
    - Documented treatment plan including if planned procedures are reversals
- For procedures in Criteria I.B.2.b.:
    - Documentation that the intervention would improve otherwise documented significant gender dysphoria
- In addition to the above, for facial gender confirmation surgery:

- The surgical plan must include a description of how the requested procedures will address the client's noncongruent features, feminize or masculinize the face, and treat the individual's gender dysphoria. All codes requested must be addressed in the documented surgical plan to determine medical necessity of requested procedures.

- In addition to the above, for endometrial ablation:
  - Endometrial histopathological report or documentation cervical stenosis precludes endometrial sampling and D&C is planned to be completed concomitantly with ablation procedure.
  - Hysteroscopy, sonohysterography (SIS), or pelvic ultrasound report

CROSS REFERENCES

1. Endometrial Ablation, Surgery, Policy No. 01
2. Cosmetic and Reconstructive Surgery, Surgery, Policy No. 12
3. Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants, Surgery, Policy No. 40
4. Reduction Mammaplasty, Surgery, Policy No. 60
5. Autologous Fat Grafting to the Breast and Adipose-derived Stem Cells, Surgery, Policy No. 182
6. Hysterectomy, Surgery, Policy No. 218
7. Medication Policy Manual, Note: Click the link for the appropriate Medication Policy. Once the medication policy site is open, do a find (Ctrl+F) and enter drug name in the find bar to locate the appropriate policy.

BACKGROUND

This policy supports applicable professional association statements,[1-5] and is also intended to support the Affordable Care Act (ACA) Section 1557 final implementing regulations published on May 18, 2016, and applicable state requirements[6].

MEDICAL AND SURGICAL INTERVENTIONS FOR GENDER DYSPHORIA

A clinical diagnosis of gender dysphoria is required prior to intervention for the disorder. Gender affirming interventions typically include hormone therapy and in some cases surgical procedures. Psychotherapy followed by hormone therapy is often the first medical treatment sought, although not all transgender individuals on hormone therapy choose to undergo gender affirming surgery.[2]

Gender Dysphoria

Gender dysphoria is defined by the Diagnostic and Statistical Manual of Mental Disorders DSM-5 Diagnostic Criteria as follows:[7]

Gender Dysphoria in Children 302.6

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion 1):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for

wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen insensitivity syndrome).
Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults 302.85

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated 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 (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
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).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen

insensitivity syndrome).
Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Post transition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female).

Hormone Therapy

Hormone therapy is undertaken in order to feminize or masculinize individuals' bodies to conform to their desired gender identities. For transgender individuals, hormone replacement therapy (HRT) causes the development of many of the secondary sexual characteristics of their gender identity. Prescribed hormones differ depending upon the natal gender of the individual. For individuals seeking to feminize, hormone treatment may include estradiol, finasteride, and spironolactone. For individuals seeking to masculinize, hormone treatment may include androgenic hormones such as testosterone.

Surgical Interventions

Surgical intervention for gender dysphoria differs depending upon the gender assigned at birth. For individuals who are assigned male at birth (AMAB), surgery may involve orchiectomy, vaginoplasty, and gender-affirming breast surgery. Complications rates related to vaginoplasty may include the formation of granulation tissue, wound dehiscence, fistulas from the bladder or bowel into the vagina, and stenosis of the neovaginal canal or urethra.[5, 8]

For individuals who are assigned female at birth (AFAB), surgery may involve gender-affirming chest surgery, hysterectomy/oophorectomy, metoidioplasty, and phalloplasty. The creation of a neophallus for these patients is a multistage reconstructive procedure. Currently, techniques for penile reconstruction procedures vary and complications may include frequent urinary tract stenoses and fistulas, diverticulae, and mucocele due to vaginal remnant.[5, 9] Mastectomy may involve a complete resection of all breast tissue; however, the nipple/areola sparing technique is typically performed to preserve the nipple/areola. For those who are taking androgen hormones, menstruation usually ceases with the medication intervention alone. In those who experience continued uterine bleeding other hormonal regimes may be attempted, or endometrial ablation.[10]

There are various additional surgical procedures which may be sought in order to complete the physical gender transformation and align an individual to their gender identity. To date, studies assessing these procedures have limitations, including small sample sizes and heterogeneous assessments and World Professional Association for Transgender Health (WPATH) recommends further study.

EVIDENCE SUMMARY

Evidence regarding interventions for gender dysphoria in transgender individuals primarily consists of systematic reviews consisting of small cohort studies. Randomized clinical trials

(RCTs) comparing gender dysphoria interventions with no intervention are ideal. However, there are challenges in conducting RCTs for these interventions due to several factors, such as small patient populations, and ethical concerns regarding the high morbidity and mortality rates associated with no intervention. Therefore, large RCTs are not anticipated. This policy relies on the following systematic reviews and non-randomized studies, as well as professional association recommendations to support applicable federal and state requirements.

SYSTEMATIC REVIEWS

Aristizabal (2024) published a systematic review (SR) summarizing studies, including upper and lower body contouring procedures in transgender patients.[11] A total of 15 studies, including trans male chest wall contouring, trans female breast augmentation, and lower body contouring, with 1811 patients were included. The double incision (DI) techniques consistently resected more tissue and had better BODY Q scores. Bleeding was increased in periareolar, semicircular, and obese patients with DI techniques. Nipple depigmentation and sensation loss were more common with double-incision-free nipple graft techniques (DIFNG). Lower body contouring patients had average implant sizes bigger than 200 mL and reported two gluteal implant displacements, one exposure, and one rupture. Eight percent of patients who underwent large-volume fat grafting reported dissatisfaction due to fat reabsorption. Variations of the DIFNG technique continue to be the most common approach; however, nipple depigmentation and loss of sensation are also more common with this technique. There is no evidence that hormonal therapy may play a role regarding increased bleeding with periareolar techniques. For lower-body trans female contouring, implants could help with the longevity of contouring results in patients needing large-volume fat grafting. There is an increasing evaluation of gender-affirming body contouring patient-reported outcomes; however, there is still a need for a validated way to report satisfaction scores in lower body contouring.

Kumar (2022) published a systematic review (SR) evaluating the health-related outcomes of oophorectomy in transmasculine and gender diverse (TMGD) population treated with chronic testosterone therapy in order to guide clinicians and patients in the decision to retain or remove their ovaries.[12] A total of 39 studies were included. Three studies discussed fertility outcomes, 11 assessed histopathological changes to the ovaries, six discussed ovarian oncological outcomes, eight addressed endocrine considerations, three discussed cardiovascular health outcomes, and eight discussed bone density. No studies were found that examined surgical outcomes or neurocognitive changes. There is limited evidence to suggest that fertility preservation is successful after total hysterectomy with bilateral salpingectomy with ovarian retention. Current evidence does not support regular reduction in testosterone dosing following oophorectomy. Estradiol levels are likely higher in individuals that choose ovarian retention, but this has not been clearly demonstrated. Although bone mineral density decreases following oophorectomy, data demonstrating an increased fracture risk are lacking. No studies have described the specific impact on neurocognitive function, or changes in operative complications. Further research evaluating long-term health outcomes of oophorectomy for TMGD individuals treated with chronic testosterone therapy is warranted to provide comprehensive, evidence-based healthcare to this patient population.

Coon (2022) published a SR of facial gender affirming surgery following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.[13] A total of 21 articles were identified addressing facial gender surgery. The majority were case series published by the same few authors and included relatively limited numbers of participants. In the 16 studies that included patient-centered outcomes, most reported high rates of satisfaction and improved

quality of life. Seven studies reported complications (mostly minor), five studies reported whether patients sought revision surgery (4% underwent revision), and seven studies assess patients' perceptions of their postsurgical face and change in self-perceived femininity (80% reported feeling more feminine as a result of surgery).

Javier (2022) published a systematic review of surgical satisfaction and quality of life outcomes long-term (at least one year) following gender-affirming surgery.[14] A total of 79 studies met inclusion criteria. All were rated as low quality. Strength of evidence (SoE) was graded on a number of factors, including sample size and use of a control group. No studies evaluating facial masculinization surgery or vocal cord surgery in transgender men met inclusion criteria. Overall, included studies primarily reported positive surgical satisfaction and quality of life outcomes at the one year or longer follow-up. The authors reported that direct evidence with medium study limitations suggests that most transgender individuals report satisfaction with their chest, genital facial, vocal cord, and Adam's apple removal surgeries (SoE high) and that the vast majority of transgender individuals do not regret undergoing chest/genital surgery (SoE medium). The authors also reported that low SoE from studies with high limitations suggests that transgender men who underwent chest surgery reported moderately high levels of psychological and social functioning comparable to transgender men who did not undergo chest surgery and transgender women overall reported improvements in their psychosocial wellbeing from pre- to post-surgery. Evidence rated as high and medium SoE, respectively, suggest positive outcomes for sexual wellbeing following chest and genital surgery and for self-esteem levels following genital surgery. Evidence rated as medium SoE was reported as suggesting positive happiness levels following gender and facial surgery, lower feelings of incongruence with gender identity and positive and/or improved health-related quality of life outcomes following facial surgery and voice surgery. Low SoE was reported for evidence suggesting that most transgender women who undergo chest surgery reported that their gender dysphoria was resolved and transgender men who undergo genital surgery have a "well-balanced" emotional stability.

Wernick (2019) published a systematic review of the psychological benefits of gender affirming surgery.[15] A total of 33 studies met inclusion criteria. The key concepts searched were quality of life, gender-confirmation surgical procedures, and transgender persons. Sixteen of the identified studies addressed compared pre- and post-surgical data, while 17 studies compared between-group differences. No meta-analysis was completed. Most studies demonstrated a trend of better mental health in transgender individuals who underwent surgeries, but not all reported improvements were statistically significant. The systematic review concluded that gender affirming surgery may lead to psychological benefits for individuals with gender dysphoria and that more research is needed to understand the factors that contribute to the outcomes following these surgeries.

Berli (2017) published a review of the available literature regarding facial gender confirmation surgery (FGCS).[16] The literature search went through December, 2016. The evidence was evaluated using the Oxford Centre for Evidence-Based Medicine suggestions for levels of evidence. Based on their findings, Berli and colleagues recommended that the next World Professional Association for Transgender Health (WPATH) Standards of Care version should include specific FGCS procedures. The authors also recommended replacing the historical term, facial feminization surgery (FFS) with more inclusive terminology – facial gender confirmation surgery. The body of evidence regarding FGCS is limited to case reports and case series. The authors found most data did not include quality-of-life outcome measures, and when reported, standardized instruments were not utilized. FGCS procedures were

categorized by the authors as structural (e.g., forehead reconstruction, rhinoplasty), and secondary nonstructural procedures (e.g., blepharoplasty, upper lip shortening techniques). The review was limited by the paucity of data on FGCS as a treatment for gender dysphoria. In addition, methodological limitations of the review included but were not limited to, lack of transparent study selection and a transparent, comprehensive assessment of study quality and risk of bias. These limitations prohibit conclusions about overall health outcomes.

Nonrandomized Studies

Primary evidence is limited to cohort studies with a variety of methodological limitations, including but not limited to small sample size, short-term follow-up, lack of comparison group, and varied treatment methods. Many of these studies and their limitations are discussed in the systematic reviews above. Despite these limitations, significant improvements in quality of life, psychological comorbidities, and sexual functioning were consistently reported in patients who received gender-confirming medical treatments.[17] Below are summaries of representative publications not addressed in the above systematic reviews.

Park (2022) reported long-term outcomes following gender affirming surgery.[18] Based on chart review, 97 individuals with comprehensive preoperative assessment for gender dysphoria at a tertiary care center from 1970 to 1989 were identified for follow-up. Of these, 15 agreed to participate in a phone interview and survey. The mean age was 65.5 (range 58 to 76). Nine respondents were transmasculine and six were transfeminine. Body congruence with self-image was rated at 89.5 out of 100 for all respondents, and 91.3 and 87.5 for transmasculine and transfeminine respondents, respectively. Pre- versus 40 years postoperative reports of suicidal ideation were eight versus one, mental health treatment was ten versus six, and depression was eight versus seven.

Almazan and Keuroghlian (2021) analyzed data from the 2015 US Transgender Survey to assess the relationship between gender affirming surgeries and mental health outcomes.[19] Survey respondents who reported having undergone gender affirming surgeries were compared with respondents who reported desiring gender affirming surgery but not having undergone any. A total of 27,715 individuals responded to the survey, of whom 12.8% reported having undergone one or more types of gender affirming surgery and 59.2% reported a desire to undergo gender affirming surgery but reported no prior gender affirming surgeries. Undergoing one or more type of gender affirming surgery was associated with reduced severe psychological distress (past month), smoking (past year), and suicidal ideation (past year), adjusted for sociodemographic factors and other gender affirming care ($p<0.001$ for all). Binge alcohol use (past month) and suicide attempts were not significantly different between groups.

Summary

The evidence is limited by a lack of well-designed studies comparing the safety and effectiveness gender affirming surgery to no treatment or to hormone therapy alone. There are challenges in conducting these large studies, and therefore such studies are not expected in the near future. Although additional research is needed, the research addressing genital and chest surgeries has consistently suggested significant improvement in symptoms and overall quality of life. With regard to other surgeries, such as body contouring, more research is needed to understand their effect on health outcomes.

PRACTICE GUIDELINE SUMMARY

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

The World Professional Association for Transgender Health (WPATH) is a multidisciplinary professional society representing the specialties of medicine, psychology, social sciences and law that has published clinical guidelines regarding health services for patients with gender disorders. In 2022, WPATH approved the update of their evidence and consensus-based guideline, the *Standards of Care (SOC) for the Health of Transgender and Gender Diverse People, 8th Version*.[5] WPATH guidelines describe gender affirming surgery as "a constellation of procedures designed to align a person's body with their gender identity."

Physical Interventions for Adolescents

The WPATH guidelines include section on care and treatment of transgender adolescents. This section includes information on gender development during adolescence as well as challenges of adolescent transgender care. Regarding consideration of ages for gender-affirming medical and surgical treatment for adolescents, WPATH guidelines state that "[a]ge has a strong, albeit imperfect, correlation with cognitive and psychosocial development and may be a useful objective marker for determining the potential timing of interventions." They go on to state that "[h]igher (i.e., more advanced) ages may be required for treatments with greater irreversibility, complexity, or both. This approach allows for continued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments." In addition, they highlight that "[g]ender-diverse youth should fully understand the reversible, partially reversible, and irreversible aspects of a treatment, as well as the limits of what is known about certain treatments."

Assessment Process

WPATH guidelines indicate that surgical interventions can be initiated by a referral from a qualified mental health professional. Regarding referrals for adults, they state:

- Health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment should liaise with professionals from different disciplines within the field of trans health for consultation and referral, if required (Graded as suggested criteria)
- If written documentation or a letter is required to recommend gender affirming medical and surgical treatment (GAMST), only one letter of assessment from a health care professional who has competencies in the assessment of transgender and gender diverse people is needed.

Regarding referrals for adolescents, they state:

- A comprehensive biopsychosocial assessment including relevant mental health and medical professionals;
- Involvement of parent(s)/guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible;
- If written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST), only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical and mental health professionals (MHPs).

Criteria for Surgery

Adults

a. Gender incongruence is marked and sustained;
b. Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access health care;
c. Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
d. Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options;
e. Other possible causes of apparent gender incongruence have been identified and excluded;
f. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed;
g. Stable on their gender affirming hormonal treatment regime (which may include 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).

Adolescents

a. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
b. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
c. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
d. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
e. At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

Facial Gender Affirming Surgery

The WPATH guidelines state that “[w]hile gender-affirming facial surgery for [assigned female at birth] individuals is an emerging field, current limited data points toward equal benefits in select patients. Future studies are recommended.”

THE ENDOCRINE SOCIETY

In 2017, the Endocrine Society in conjunction with American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health published updated guidelines for the treatment of gender-dysphoric/gender-incongruent persons.[10] The guideline employed transparent methods for evidence review and for rating the quality of evidence. Guidelines were referenced as *recommendations* or *suggestions*, by the numbers 1 and 2, respectively.

Evidence was ranked as very low-quality |⊕○○○; low quality |⊕⊕○○; moderate quality |⊕⊕⊕○; and high quality |⊕⊕⊕⊕. The consortium made the following statements:

1.0 Evaluation of Youth and Adults

1.1 We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/ gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/ gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (e.g., body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (e.g., body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕○○)

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕○)

2.0 Treatment of Adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕○○)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕○○)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕○○)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the

persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕○○).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/ gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents 16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕○○○)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕○○)

3.0 Hormonal Therapy for Transgender Adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕○)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕○)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕○○)

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

4.0 Adverse Outcome Prevention and Long-term Care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕○○)

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕○○)

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)

4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕○○)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕○○○)

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for Sex Reassignment and Gender Confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⌖⌖○○)
5.2. We advise that clinicians approve genital gender affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
5.4. We recommend that clinicians refer hormone treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⌖○○○)
5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⌖⌖○○).
5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⌖○○○)

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGY

In 2021, the American College of Obstetricians and Gynecology (ACOG) published an updated committee opinion regarding care for health care for transgender and gender diverse individuals.[20] These guidelines are not based on evidence. ACOG makes the following statements:

"Obstetrician–gynecologists should be prepared to assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies. Hormonal and surgical therapies for transgender patients may be requested, but should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender patients."

Regarding adolescents, ACOG highlights age-specific concerns with a focus on medical management, stating "Consensus guidelines support initiating medical therapy after an adolescent has an established diagnosis of transgender identity and has reached Tanner stage II development."

In addition, ACOG guidelines made specific recommendations regarding surgery and screening for both female-to-male and male-to-female patients:

Female-to-Male Transgender Individuals

Surgery

Transmasculine individuals may choose chest reconstruction, hysterectomy with or without salpingo-oophorectomy, or metoidioplasty, phalloplasty, or both.

Screening

For transmasculine individuals, screening includes breast cancer screening for patients who have breast tissue and cervical cancer screening for those who have a cervix.

…on the basis of limited data, recommendations for screening for endometrial cancer for transmasculine individuals are no different than for cisgender women. Additionally, evaluation of transmasculine individuals with abnormal uterine bleeding are the same as those for cisgender women

Male-to-Female Transgender Individuals

Surgery

Potential procedures for transfeminine individuals include breast augmentation, orchiectomy, vaginoplasty, and facial feminization surgeries.

Screening

A neovagina does not require routine cytologic screening. Prostate cancer screening for transfeminine individuals should follow the recommendations for cisgender men.

It is likely that transfeminine individuals have a lower risk of breast cancer than cisgender women… General consensus is that screening should begin after 50 years of age and a minimum of 5 years of feminizing hormone use, with a health care professional-patient discussion about the potential harms of over screening.

SUMMARY

For member contracts subject to Washington's Gender Affirming Treatment Act (SSB 5313) or Oregon Reproductive Health Rights (HB 2002)

For member contracts subject to the Washington Gender Affirming Treatment Act (SSB 5313) or Oregon Reproductive Health Rights (HB 2002), criteria for gender affirming interventions are based on the research, guidelines developed using the available evidence and expert clinical consensus, and on the Act. Therefore, for member contracts subject to the Washington Gender Affirming Treatment Act (SSB 5313) or Oregon Reproductive Health Rights (HB 2002), gender affirming interventions for gender dysphoria may be considered medically necessary when specified policy criteria are met.

For member contracts subject to the Washington Gender Affirming Treatment Act (SSB 5313) or Oregon Reproductive Health Rights (HB 2002), criteria for gender affirming interventions are based on the Act and on guidelines developed using the available evidence and expert clinical consensus. Therefore, for these members, when these criteria are not met, gender affirming interventions for gender dysphoria are considered not medically necessary.

For member contracts *not* subject to Washington's Gender Affirming Treatment Act (SSB 5313) or Oregon Reproductive Health Rights (HB 2002)

The research lacks well-designed studies comparing the safety and effectiveness of no intervention for gender dysphoria with interventions such as gender affirming surgery. However, there are challenges in conducting large studies to evaluate existing treatments,

and such studies are not expected in the near future. Although additional research is needed, the research has consistently suggested significant improvement in symptoms and overall quality of life in those who have received certain interventions for gender dysphoria. The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) for the Health of Transgender and Gender Diverse People recommend that specific criteria are met prior to surgical interventions for gender dysphoria. These guidelines are based on evidence and expert clinical consensus and the included criteria were developed to promote optimal patient care. Therefore, gender affirming interventions for gender dysphoria may be considered medically necessary when specified policy criteria are met.

The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) for the Health of Transgender and Gender Diverse People recommend that specific criteria are met prior to surgical interventions for gender dysphoria. These guidelines are based on evidence and expert clinical consensus and the included criteria were developed to promote optimal patient care. Therefore, when criteria are not met, gender affirming interventions for gender dysphoria are considered not medically necessary.

There are no evidence-based clinical practice guidelines that recommend gender affirming surgical interventions not listed in Criterion I.B.2. or revision to a previous gender affirming surgery because of dissatisfaction with the appearance improve health outcomes. Therefore, gender affirming surgical interventions not listed in Criterion I.B.2. and revision to a previous gender affirming surgery because of dissatisfaction with the appearance are considered not medically necessary.

The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) for the Health of Transgender and Gender Diverse People describe reversible and irreversible interventions, and the ideal order and timing of these approaches. Surgery as an intervention is considered irreversible. Therefore, reversal of gender affirming surgery for gender dysphoria is considered not medically necessary.

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CODES

NOTES:

- Follicular unit extraction (FEU) of individual hairs is correctly coded with code 15775 or 15776 and is determined by the number of "punch grafts" performed. Be advised that standard CMS Medically Unlikely Edits (MUEs or Maximum Units of Service) will apply.
- Code 17999 should be reported for laser hair removal. This code may also be used for abdominoplasty or calf/pectoral implants.
- Codes 31552, 31554, 31580, 31584, 31587, and 31591 are not appropriate to use to represent voice modification. Unlisted code 31599 should be reported instead.
- Code 31899 should be reported for reduction thyroid chondroplasty (e.g. tracheal shave; reduction of the thyroid cartilage or Adam's Apple).
- Code 40799 should be reported for lip reduction.
- Code 55899 should be reported for phallic reconstruction/phalloplasty.
- Codes 55970 and 55980 are non-specific. The specific procedure code(s) must be requested in place of these non-specific codes.

Codes	Number	Description
CPT	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
	11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
	11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
	11954	Subcutaneous injection of filling material (eg, collagen); over 10 cc
	11970	Replacement of tissue expander with permanent implant
	11971	Removal of tissue expander(s) without insertion of implant
	14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
	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) Just 1 primary procedure 14301
	15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)
	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
	15770	Graft; derma-fat-fascia
	15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
	15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure).
	15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
	15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc

	injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15820	Blepharoplasty, lower eyelid
15821	;with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	;with excessive skin weighting down lid
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	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
19499	Unlisted procedure, breast
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible
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)
21137	Reduction forehead; contouring only

21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
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
21299	Unlisted craniofacial and maxillofacial procedure
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	;complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	;including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	;intermediate revision (bony work with osteotomies)
30450	;major revision (nasal tip work and osteotomies)
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
31599	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
31899	Unlisted procedure, trachea, bronchi
40799	Unlisted procedure, lips
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type)
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion
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 of female urethra
54125	Amputation of penis; complete (Penectomy)
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
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55899	Phallic reconstruction/Phalloplasty (Unlisted procedure, male genital system)
55970	intersex surgery; male to female
55980	intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57106	Vaginectomy, partial removal of vaginal wall
57110	Vaginectomy, complete removal of vaginal wall;
57291	Construction of artificial vagina; without graft
57292	Construction of 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 for 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)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), 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, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58353	Endometrial ablation, thermal, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
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)
	58563	Hysteroscopy, surgical; with endometrial ablation (eg. Endometrial resection, electrosurgical ablation, thermoablation)
	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)
	58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
	67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
	67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
	67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
	67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
	67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
	67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
	67909	Reduction of overcorrection of ptosis
	67950	Canthoplasty (reconstruction of canthus)
HCPCS	C1789	Prosthesis, breast (implantable)
	C1813	Prosthesis, penile, inflatable
	C2622	Prosthesis, penile, noninflatable
	L8039	Breast prosthesis, not otherwise specified
	L8600	Implantable breast prosthesis, silicone or equal

Date of Origin: *September 2014*