# Medical Coverage Policy | Gender Affirming Care

**EFFECTIVE DATE:** 01|01|2024
**POLICY LAST REVIEWED:** 10|18|2023

## OVERVIEW
This policy documents the coverage and guidelines for Gender Affirming Care (GAC) applicable to Medicare Advantage Plans and Commercial Products.

## MEDICAL CRITERIA
None

## PRIOR AUTHORIZATION
Prior authorization is required for Medicare Advantage Plans and recommended for Commercial Products for all services in this policy to determine member eligibility. See Eligibility Criteria in the Policy Statement below.

Some services identified with an asterisk in the Policy Statement may also appear in other policies as needing prior authorization to determine medical necessity. However, when these services are filed for a member who has met the Eligibility Criteria, and who has a benefit for gender affirming care, and when the service is filed for the purpose of gender affirming care with an ICD-10-CM diagnosis code identified in the Coding section below, the service does not need prior authorization to determine medical necessity. The Prior Authorization via Web Based Tool for Procedures policy in the Related Policies section below can be consulted for a listing of procedure codes that are reviewed for medical necessity for diagnoses other than gender dysphoria.

## POLICY STATEMENT
**Medicare Advantage Plans and Commercial Products**
Prior Authorization is required for Medicare Advantage Plans and recommended for Commercial Products to determine if the member is eligible for coverage.

Eligibility Criteria: Members are eligible for gender affirming care services when the documentation submitted confirms that:

- The member has been diagnosed with gender dysphoria
- The member has successfully lived and worked within a gender role that is congruent with their gender identity full-time for at least 12 months.

**Surgical Treatment for Gender Affirming Care**
In plans that include a benefit for gender affirming care and when all of the eligibility criteria above are met, the following surgeries are covered:

- Breast Augmentation Note: augmentation mammoplasty (including breast prosthesis if necessary) if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role
- Breast reconstruction
- Clitoroplasty
- Colovaginoplasty
- Colpectomy/Vaginectomy

- Facial Surgery*
- Hair Removal/Transplant*
- Hysterectomy
- Labiaplasty
- Lipoplasty*
- Mastectomy
- Metoidioplasty
- Orchiectomy
- Penectomy
- Phalloplasty
- Reduction mammoplasty
- Salpingo-oophorectomy
- Scrotoplasty
- Testicular implants
- Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage (CPT Code 31899)
- Urethroplasty
- Vaginoplasty
- Vocal Cord Surgery*

* These services may be covered without additional medical necessity review when:

- the eligibility criteria above are met, AND
- performed for the purpose of gender affirming care, AND
- filed with an ICD-10-CM diagnosis code for gender dysphoria (see Coding Section), AND
- Gender Affirming Care is a covered benefit under the member's plan.

**Hair Removal**

Hair removal procedures may be covered in the following circumstances:

- To treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure, or
- When filed with one of the ICD-10-CM diagnosis codes for gender dysphoria; see Coding section.

**Hormone Therapy**

Hormone Therapy is not addressed in this policy but may be subject to prior authorization. Please refer to the Prior Authorization of Drugs policy and/or the applicable BCBSRI Pharmacy Program Formulary

Other services (e.g., laboratory, pharmacy, radiology, or behavioral health services) are covered when rendered as part of gender affirming care as they are for other diagnoses, according to the plan design.

**Commercial Products**

Procedures identified in this policy are covered under the applicable conditions in those plans that include a benefit for gender affirming care. Coding instructions outlined must be followed to ensure correct claims processing.

For services related to fertility and Gender Affirming Care, please refer to the Infertility Services policy in the Related Policies section. Please note, some plans have customized benefits for coverage. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet to determine whether the member's plan has customized benefit coverage.

**Medicare Advantage Plans**
Procedures identified in this policy are covered under the applicable conditions in those plans that include a benefit for gender affirming care. Coding instructions outlined must be followed to ensure correct claims processing.

For services related to Infertility and Gender Affirming Care, please refer to the Infertility Services policy in the Related Policies section.

## COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable surgery/gender affirming care benefits/coverage.

Inclusion of a service in this policy does not guarantee coverage of the service requested. Not all services addressed in this policy may be covered by all plans depending on group-specific benefits and exclusions. Benefit coverage for health services is determined by the member specific benefit plan document. Please refer to the member contract language to determine if the member's plan includes benefits for these services.

## CODING

**Medicare Advantage Plans and Commercial Products**
The following CPT codes may be covered if the eligibility criteria above are met, and if Gender Affirming Care is a covered benefit under the member's plan, when performed for the purpose of gender affirming care:

**19301** Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
**19303** Mastectomy, simple, complete
**19316** Mastopexy
**19318** Breast Reduction
**19325** Breast augmentation with implant
**19350** Nipple/areola reconstruction
**31899** Unlisted procedure, trachea, bronchi
**53430** Urethroplasty, reconstruction of female urethra
**54125** Amputation of penis; complete
**54520** Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
**54660** Insertion of testicular prosthesis (separate procedure)
**54690** Laparoscopy, surgical; orchiectomy
**55175** Scrotoplasty; simple
**55180** Scrotoplasty; complicated
**55899** Unlisted procedure, male genital system
**56625** Vulvectomy simple; complete
**56800** Plastic repair of introitus
**56805** Clitoroplasty for 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 of vaginal wall
**57111** Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
**57291** Construction of artificial vagina; without graft
**57292** Construction of artificial vagina; with graft
**57335** Vaginoplasty for intersex state
**58150** Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)

**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)
**58275** Vaginal hysterectomy, with total or partial vaginectomy
**58280** Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
**58285** Vaginal hysterectomy, radical (Schauta type operation)
**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)
**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)
**58999** Unlisted procedure, female genital system (nonobstetrical)

The CPT procedure codes identified below may be covered when:

- the eligibility criteria above are met, AND
- performed for the purpose of gender affirming care, AND
- filed with one of the following ICD-10-CM diagnosis codes as **primary**, AND
- Gender Affirming Care is a covered benefit under the member's plan.

**ICD-10-CM Diagnosis Codes – must be filed as primary diagnosis for coverage of gender affirming care services.**
F64.0
F64.1
F64.2
F64.8
F64.9
Z87.890

**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

**11922** Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
**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 10.0 cc
**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
**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
**15734** Muscle, myocutaneous, or fasciocutaneous flap; trunk
**15738** Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
**15750** Flap; neurovascular pedicle
**15757** Free skin flap with microvascular anastomosis
**15758** Free fascial flap with microvascular anastomosis
**15769** Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, 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
**15780** Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
**15781** Dermabrasion; segmental, face
**15782** Dermabrasion; regional, other than face
**15783** Dermabrasion; superficial, any site (eg, tattoo removal)
**15786** Abrasion; single lesion (eg, keratosis, scar)
**15787** Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
**15788** Chemical peel, facial; epidermal
**15789** Chemical peel, facial; dermal
**15792** Chemical peel, nonfacial; epidermal
**15793** Chemical peel, nonfacial; dermal
**15819** Cervicoplasty
**15820** Blepharoplasty, lower eyelid
**15821** Blepharoplasty, lower eyelid; with extensive herniated fat pad
**15822** Blepharoplasty, upper eyelid
**15823** Blepharoplasty, upper eyelid; 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
**15389** 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
**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
**21138** Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
**21139** Reduction forehead; contouring and setback of anterior frontal sinus wall
**21172** Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
**21175** Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
**21179** Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
**21180** Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
**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
**21299** Unlisted craniofacial and maxillofacial procedure
**21499** Unlisted musculoskeletal procedure, head
**21899** Unlisted procedure, neck or thorax
**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
**40500** Vermilionectomy (lip shave), with mucosal advancement

**40510** Excision of lip; transverse wedge excision with primary closure
**40520** Excision of lip; V-excision with primary direct linear closure
**40525** Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)
**40527** Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
**67900** Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

**Hair Removal**
To ensure correct claims processing, claims for hair removal should be filed with the following CPT codes and an ICD-10-CM code above when applicable:
Electrolysis:
**17380** Electrolysis epilation, each 30 minutes
Laser Hair Removal:
**17999** Unlisted procedure, skin, mucous membrane and subcutaneous tissue

The following CPT codes are not to be used for pricing or claims processing, as they are not specific to the individual procedure being performed. Claims for services addressed in this policy should be filed with specific procedure codes above.
**55970** Intersex surgery; male to female
**55980** Intersex surgery; female to male

## RELATED POLICIES
Cosmetic Services and Procedures
Infertility Services
Non-Reimbursable Health Service Codes
Prior Authorization of Drugs
Prior Authorization via Web-Based Tool for Procedures
Surgical and Debulking Treatments for Lymphedema
Unlisted Procedures

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Provider Update, November 2023
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## REFERENCES
Not applicable