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WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

Gender Reassignment Surgery

Policy Number: HS-317

Original Effective Date: 12/3/2015

**Revised Date(s): 12/8/2016; 4/6/2017;
7/6/2017; 9/7/2017; 3/1/2018**

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Gender Dysphoria (GD) is defined by the *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5™)* as a condition characterized by the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender also known as "natal gender", which is the individual's sex determined at birth. Individuals with gender dysphoria experience confusion in their biological gender during their childhood, adolescence or adulthood. Also, they demonstrate clinically significant distress or impairment in social, occupational, or other important areas of functioning. GD is characterized by the desire to have the anatomy of the other sex and to be regarded by others as a member of the other sex. Individuals with GD may develop social isolation, emotional distress, poor self-image, depression and anxiety. A diagnosis of GD is not made if the individual has a congruent physical intersex condition such as congenital adrenal hyperplasia.

Gender dysphoria cannot be treated by psychotherapy or through medical intervention alone. Integrated therapeutic approaches are used to treat GD, including psychological interventions and gender reassignment therapy. Gender reassignment therapy, either as male-to-female transsexuals (transwomen) or as female-to-male transsexuals (transmen), consists of medical and surgical treatment that changes primary or secondary sex characteristics. Initially, the individual may go through the real-life experience in the desired role, followed by cross-sex hormone therapy and gender reassignment surgery to change the genitalia and other sex characteristics. The difference between cross-sex hormone therapy and gender reassignment surgery is that the surgery is considered an irreversible physical intervention. Gender reassignment surgical procedures are not without risk for complications; individuals should undergo an extensive evaluation to explore psychological, family, and social issues prior to and post-surgery. Additionally, certain surgeries may improve gender-appropriate appearance but provide no significant improvement in physiological function. These surgeries are considered cosmetic and are non-covered.¹

Mental health professionals working with this population should possess the following characteristics:²

- Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. In addition, the professional should also have documented credentials from the relevant licensing board or equivalent; **AND**
- Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; **AND**
- Ability to recognize and diagnose co-existing mental health concerns and distinguish these from GD; **AND**
- Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; **AND**
- 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.

POSITION STATEMENT

Applicable To:

- Medicaid – see applicable market specific criteria below, not applicable to Nebraska
- Medicare

Exclusions / Limitations

WellCare considers the following procedures cosmetic for the treatment of gender dysphoria and **are not covered** (list is not all-inclusive):

- Liposuction (removal of fat)
- Rhinoplasty (reshaping of nose)
- Rhytidectomy (face lift)
- Blepharoplasty (removal of redundant skin of upper and/or lower eyelids and protruding periorbital fat)
- Hair removal/ hair transplantation
- Facial feminizing (e.g., facial bone reduction)
- Chin augmentation (e.g., reshaping or enhancing the size of the chin)
- Collagen injections
- Lip reduction/enhancement: decreasing/enlarging lip size
- Cricothyroid approximation: voice modification that raises the vocal pitch by simulating contractions of the cricothyroid muscle with sutures
- Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage
- Laryngoplasty (reshaping of laryngeal framework [voice modification surgery])
- Mastopex (breast lift)

Coverage

Readiness criteria for gender reassignment surgery includes the individual demonstrating progress in consolidating gender identity, and demonstrating progress in dealing with work, family, and interpersonal issues resulting in an improved state of mental health. To check the eligibility and readiness criteria for gender reassignment surgery, it is important for the individual to discuss the matter with a professional provider who is well-versed in the relevant medical and psychological aspects of GD. The mental health and medical professional providers responsible for the individual's treatment should work together in making a decision about the use of cross-sex hormones during the months before the gender reassignment surgery. Transsexual individuals should regularly participate in psychotherapy in order to have smooth transitions and adjustments to the new social and physical outcomes.¹

Claims for gender reassignment surgery will be reviewed on a case by case basis. Surgical treatment of gender reassignment surgery for gender dysphoria may be eligible when medical necessity and documentation requirements outlined within this guideline.¹

Non-Surgical Treatment

Initiation of cross-sex hormone therapy may be provided after a psychosocial assessment has been conducted and informed consent has been obtained by a health professional. Criteria for cross sex hormone therapy includes:

- Persistent, well-documented gender dysphoria; **AND**
- Capacity to make a fully informed decision and to consent for treatment; **AND**
- Member must be at least 18 years of age; **AND**
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The presence of co-existing mental health concerns does not necessarily preclude access to cross-sex hormones. These concerns should be managed prior to or concurrent with treatment of gender dysphoria.

Cross-sex hormonal interventions are not without risk for complications, including irreversible physical changes. Medical records should indicate that an extensive evaluation was completed to explore psychological, family and social issues prior to and post treatment. Providers should also document that all information has been provided and understood regarding all aspects associated with the use of cross-sex hormone therapy, including both benefits and risks.

Gender Reassignment Surgery

Gender reassignment surgery **is considered medically necessary** when criteria are met for the requested procedures listed below:

1. Requirements for mastectomy for female-to-male patients

- Single letter of referral from a qualified mental health professional¹; **AND**
- Persistent, well-documented gender dysphoria; **AND**
- Capacity to make a fully informed decision and to consent for treatment; **AND**
- Age of majority (18 years of age or older); **AND**
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

NOTE: A trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

OR

2. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female)

- Two referral letters from qualified mental health professionals, one in a purely evaluative role; **AND**
- Persistent, well-documented gender dysphoria²; **AND**
- Capacity to make a fully informed decision and to consent for treatment; **AND**

- Age of majority (18 years or older); **AND**
- If significant medical or mental health concerns are present, they must be reasonably well controlled; **AND**
- Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)

OR

3. **Requirements for genital reconstructive surgery** (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female)
- Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); **AND**
 - Persistent, well-documented gender dysphoria^{**}; **AND**
 - Capacity to make a fully informed decision and to consent for treatment; **AND**
 - Age of majority (age 18 years and older); **AND**
 - If significant medical or mental health concerns are present, they must be reasonably well controlled; **AND**
 - Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); **AND**
 - Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

[^] Referral letters from a qualified health professional (as noted in the Background) should include the following:²

1. Client's general identifying characteristics; and
2. Results of the client's psychosocial assessment, including any diagnoses; and
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; and
4. An explanation that the WPATH criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; and
5. A statement about the fact that informed consent has been obtained from the patient; and
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

^{**} *DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents*³

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more 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).

AND

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

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.

Cancer Screenings

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Professional organizations such as the American Cancer Society, American College of Obstetricians and

Gynecologists and the US Preventive Services Task Force provide recommended cancer screening guidelines to facilitate clinical decision-making by professional providers. Some cancer screening protocols are sex/gender specific based on assumptions about the genitalia for a particular gender. There is little data on cancer risk specifically in transsexual individuals.

There is difficulty in recommending sex/ gender specific screenings (e.g., breast, cervix, ovaries, penis, prostate, testicles and uterus) for transsexual individuals because of their physiologic changes. For example, transmen who have not undergone a mastectomy have the same risks for breast cancer as natal women. In transwomen, the prostate typically is not removed as part of genital surgery, so individuals who do not take feminizing hormones may be at the same risk for prostate cancer as natal men. Therefore, cancer screenings (e.g., mammograms, prostate screenings) may be indicated based on the individual's original gender. Gender specific screenings may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for transmen who have not undergone a mastectomy.
- Prostate cancer screening may be medically necessary for transwomen who have retained their prostate.

Additional Related Procedures: Surgical Treatments for Gender Reassignment ¹

When all of the above criteria are met for gender reassignment surgery, the following genital surgeries may be considered for transwomen (**male to female**):

- Orchiectomy - removal of testicles
- Penectomy - removal of penis
- Vaginoplasty - creation of vagina
- Clitoroplasty - creation of clitoris
- Labiaplasty - creation of labia
- Mammoplasty - breast augmentation
- Prostatectomy - removal of prostate
- Urethroplasty - creation of urethra

When all of the above criteria are met for gender reassignment surgery, the following genital/breast surgeries may be considered for transmen (**female to male**):

- Breast reconstruction (e.g., mastectomy) - removal of breast
- Hysterectomy - removal of uterus
- Salpingo-oophorectomy - removal of fallopian tubes and ovaries
- Vaginectomy - removal of vagina
- Vulvectomy - removal of vulva
- Metoidioplasty - creation of micro-penis, using clitoris
- Phalloplasty - creation of penis, with or without urethra
- Urethroplasty - creation of urethra within the penis
- Scrotoplasty - creation of scrotum
- Testicular prostheses - implantation of artificial testes

Gonadotropin-releasing hormone **is considered medically necessary** to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria:

- Adolescent has demonstrated a long-lasting and intense pattern of gender non-conformity or gender dysphoria (whether suppressed or expressed); **AND**
- Gender dysphoria emerged or worsened with the onset of puberty; **AND**
- Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and

functioning are stable enough to start treatment; **AND**

- Adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

The following procedures may also be a component of a gender reassignment (list is not all-inclusive):

- Abdominoplasty
- Blepharoplasty
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or growth
- Forehead lift
- Hair removal
- Hair transplantation
- Lip reduction
- Liposuction
- Mastopexy
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Voice therapy/voice lessons

Market Specific Criteria

NEW YORK⁵

Exclusions

The following services and procedures are not a covered benefit:

- Cryopreservation, storage, and thawing of reproductive tissue, and all related services and charges;
- Reversal of genital and/or breast surgery;
- Reversal of surgery to revise secondary sex characteristics;
- Reversal of any procedure resulting in sterilization; and
- Cosmetic surgery, services, and procedures, including but not limited to:
 - Abdominoplasty, blepharoplasty, neck tightening, or removal of redundant skin;
 - Breast augmentation (unless the individual has completed a minimum of 24 months of hormone therapy during which time breast growth has been negligible, or hormone therapy is medically contraindicated or the individual is otherwise unable to take hormones);
 - Breast, brow, face, or forehead lifts;
 - Calf, cheek, chin, nose, or pectoral implants;
 - Collagen injections;
 - Drugs to promote hair growth or loss;
 - Electrolysis, unless required for vaginoplasty or phalloplasty;
 - Facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty;
 - Hair transplantation;
 - Lip reduction;
 - Liposuction;
 - Thyroid chondroplasty; and
 - Voice therapy, voice lessons, or voice modification surgery.

NOTE: For purposes of this subdivision, cosmetic surgery, services, and procedures refers to anything solely directed at improving an individual's appearance.

All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization.

Coverage

Gender Dysphoria Treatment

Treatment for gender dysphoria **is considered medically necessary** when the following criteria is met:

As provided in this subdivision, payment is available for medically necessary hormone therapy and/or gender reassignment surgery for the treatment of gender dysphoria.

Gender reassignment surgery may be covered when the following criteria is met:^{6,7}

- Member is 18 years of age or older; **AND**
- Member has letters from two qualified New York State licensed health professionals who have independently assessed the individual and are referring the individual for the surgery.
 - a. One of these letters must be from a psychiatrist or psychologist with whom the individual has an established and ongoing relationship.
 - b. The other letter may be from a licensed psychiatrist, psychologist, physician, psychiatric nurse practitioner or licensed clinical social worker acting within the scope of his or her practice, who has only had an evaluative role with the individual.⁶ Together, the letters must establish that the individual:

AND

- Has a persistent and well-documented case of gender dysphoria;
- Has received hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 12 months in the case of an individual seeking genital surgery, unless such therapy is medically contraindicated or the individual is otherwise unable to take hormones;
- Has lived for 12 months in a gender role congruent with the individual's gender identity, and has received mental health counseling, as deemed medically necessary, during that time;
- Has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so, that those are reasonably well-controlled prior to the gender reassignment surgery; and
- Has the capacity to make a fully informed decision and to consent to the treatment.
- Member has documentation by a qualified medical professional to support the medical necessity of one or more of the following procedures:
 - Mastectomy; **AND/OR**,
 - Hysterectomy; **AND/OR**,
 - Salpingectomy; **AND/OR**,
 - Oophorectomy, ; **AND/ OR**,
 - Vaginectomy; **AND/OR**,
 - Urethroplasty; **AND/OR**,
 - Metoidioplasty; **AND/OR**,
 - Phalloplasty; **OR**,
 - Scrotoplasty; **AND/OR**,
 - Penectomy; **AND/OR**,
 - Orchiectomy; **AND/OR**,
 - Vaginoplasty; **AND/OR**,
 - Labiaplasty; **AND/ OR**,
 - Clitoroplasty; **AND/OR**,
 - Placement of a testicular prosthesis and penile prosthesis; **AND/ OR**,
 - Breast augmentation provided that:
 1. The individual has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the patient is otherwise unable to take hormones; **AND/ OR**,
 - Electrolysis when required for vaginoplasty or phalloplasty.

NOTE: Although the minimum age for Medicaid coverage of gender reassignment surgery is generally 18 years of age, the revised

regulations allow for coverage for individuals under 18 in specific cases if medical necessity is demonstrated and prior approval is received.

NOTE: The above services are available under fee-for-service (FFS) Medicaid **without prior approval**. With respect to Medicaid Managed Care (MMC) enrollees, administrative prior authorization requirements may be applied; however, the MMC Plan must accept the qualified medical professional's determination of medical necessity.

NOTE: Any other surgeries, services, and procedures in connection with gender reassignment not listed above, or to be performed in situations not described above, including those done to change the patient's physical appearance to more closely conform secondary sex characteristics to those of the patient's identified gender, will be covered if it is demonstrated that such surgery, service, or procedure is medically necessary to treat a particular patient's gender dysphoria, and prior approval is received. Coverage is not available for surgeries, services, or procedures that are purely cosmetic, i.e., that enhance a patient's appearance but are not medically necessary to treat the patient's underlying gender dysphoria.

Pubertal suppressants and cross-sex hormone therapy **is considered medically necessary** when the following criteria are met:

NOTE: Treatment with cross-sex hormones, including testosterone cypionate, conjugated estrogen, and estradiol, for patients who are 16 years of age or older, based upon a determination of medical necessity made by a qualified professional. Payment for cross-sex hormones treatment for a patient who is under 16 years of age and who otherwise meets these requirements will be made in specific cases if medical necessity is demonstrated by a qualified medical professional and prior approval is received.

- Members have a diagnosis of gender dysphoria; **AND,**
- Member has reached at least Tanner stage 2, and pubertal changes have resulted in an increase in gender dysphoria; **AND,**
- Member does not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment; **AND,**
- Member has adequate psychological and social support during treatment; **AND,**
- Member demonstrates knowledge and understanding of the expected outcomes of treatment with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment.

CODING

Covered CPT Codes – when criteria are met (list is not all-inclusive)

19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19325	Mammoplasty, augmentation; with prosthetic implant
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
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
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
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 tubes(s), and/or ovary(s)
- 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)
- 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)
- 58720** Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) (list is not all inclusive)

CPT Codes – *May be related to covered surgery pending medical necessity criteria review*

- 11950** Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
- 11951** Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
- 11952** Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
- 11954** Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
- 15775** Punch graft for hair transplant; 1 to 15 punch grafts
- 15776** Punch graft for hair transplant; more than 15 punch grafts
- 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 muscoloponeurotic 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
- 17380** Electrolysis epilation, each 30 minutes
- 19316** Mastopexy
- 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 (e.g., 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
- 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)

Covered ICD-10-CM Codes

- F64.1 – F64.9** Gender identity disorders
- Z87.890** Personal history of sex reassignment

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
3/1/2018	<ul style="list-style-type: none"> • Approved by MPC. No changes.
7/6/2017	<ul style="list-style-type: none"> • Approved by MPC. Added nurse practitioner to list of approved medical professionals who can supply second letter for New York members.
4/6/2017	<ul style="list-style-type: none"> • Approved by MPC. New York market specific items included.
12/8/2016	<ul style="list-style-type: none"> • Approved by MPC. No changes.
12/3/2015	<ul style="list-style-type: none"> • Approved by MPC. New.