Medical Policy
Gender Affirming Services (Transgender Services)

Table of Contents
- Policy: Commercial
- Policy: Medicare
- Authorization Information
- Description
- Policy History
- Information Pertaining to All Policies
- References
- Coding Information
- Endnotes

Policy Number: 189
BCBSA Reference Number: N/A
NCD/LCD: N/A

Related Policies
- Assisted Reproductive Services, #086
- Outpatient Psychotherapy, #423
- Prior Authorization Request for Gender Affirming Services (Transgender Services) Form, #901
- Prior Authorization Request for Electrolysis for Gender Affirming Services (Transgender Services) Form, #902

Table of Contents
Definitions....................................................................................................................2
Policy and Products....................................................................................................2
Hormone Therapy ........................................................................................................2
  Puberty Blockers......................................................................................................2
  Gender-Affirming Hormone Therapy.........................................................................2
Behavioral Health........................................................................................................3
Fertility Preservation....................................................................................................3
Surgical Services .........................................................................................................3
  Facial Procedures....................................................................................................3
  Chest Procedures....................................................................................................3
  Genital Procedures and Electrolysis..........................................................................4
  Surgical Services for Adolescents............................................................................5
  Surgical Revisions....................................................................................................5
Not Medically Necessary/Not Covered Services ........................................................5
Definitions
This policy addresses gender affirming services for transgender and gender diverse individuals, when gender identity differs from assigned sex at birth.

Please Note: According to the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines gender dysphoria as a condition where a person’s gender at birth is “contrary to the one they identify with.” This definition replaces the criteria for gender identity disorder which will no longer be used in DSM-5. However, ICD-10 codes continue to use the term gender identity disorder, and providers will need to submit claims for coverage using this diagnosis.

Policy and Products
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Hormone Therapy

Puberty Blockers
Gonadotropin-releasing hormone (GnRH) analog treatment for gender non-conforming adolescents seeking to delay puberty is covered at the discretion of the treating provider*. GnRH analogs may be used to either allow members more time for decision making purposes or as an initial step prior to further gender affirming services such as hormone therapy.

Treatment options include but are not limited to:
- Lupron
- Supprelin LA
- Vantas
- Triptodur (triptorelin).

* The following criteria are recommended by World Professional Association for Transgender Health (WPATH) Standards of Care 7th edition as minimum criteria prior to starting puberty suppressing hormones:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
2. Gender dysphoria emerged or worsened with the onset of puberty;
3. 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;
4. The 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.

Gender-Affirming Hormone Therapy
Gender-Affirming hormone therapy is covered at the discretion of the treating provider. Gender-Affirming hormone therapy options include but are not limited to:
- Estrogen, Androgen reducing medications (bicalutamide, spironolactone, GnRH agonists, 5-alpha reductase inhibitors), Progestins and Testosterone.
Methods of administration vary between these products and may be subject to formulary or tiering restrictions.

**Behavioral Health**

Supportive behavioral health services for transgender and gender diverse members with or without additional behavioral health diagnoses are covered services.

Examples of covered behavioral health services include:
- Initial evaluation
- Counseling
- Psychotherapy.

Behavioral health or substance use disorder services related to diagnoses other than gender identity disorder or gender dysphoria may be governed by other medical policies or the member’s subscriber certificate based on the service being rendered. Please see related policies section.

**Fertility Preservation**

Oocyte, embryo, or sperm retrieval, freezing and storage for up to 24 months for transgender members prior to undergoing hormone therapy or genital sex reassignment surgery may be considered MEDICALLY NECESSARY. (See medical policy #086, Infertility Diagnosis and Treatment)
- Per subscriber certificate language, cryopreservation is limited to one cycle only.

**Surgical Services**

**Facial Procedures**

Facial feminization or masculinization may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:
- Age ≥ 18
- The member has been diagnosed with gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder), and meets ALL of the following indications:
  - The desire to live and be accepted as a member of another gender other than one’s assigned sex, typically accompanied by the desire to make the physical body as congruent as possible with the identified gender through surgery and hormone treatment.
  - The new gender identity should be present for at least 12 months.
  - The member has a consistent, stable gender identity that is well documented by their treating providers, and when possible, lives as their affirmed gender in places where it is safe to do so.
  - The gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder) is not a symptom of another mental disorder.
- **Covered** procedures when medical necessity criteria are met:
  - Forehead contouring
  - Rhinoplasty
  - Mandible reconstruction
  - Trachea shave
  - Blepharoplasty
  - Brow lift
  - Cheek augmentation
  - Face lift or liposuction (only as needed in conjunction with one of the above procedures).

**Chest Procedures**

Mastectomy and/or creation of a male chest for transmasculine or gender diverse members may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:
- Age ≥ 18
• The member has been diagnosed with gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder), and meets ALL of the following indications:
  o The desire to live and be accepted as a member of another gender other than one’s assigned sex, typically accompanied by the desire to make the physical body as congruent as possible with the identified gender through surgery and hormone treatment.
  o The new gender identity has been present for at least 12 months.
  o The member has a consistent, stable gender identity that is well documented by their treating providers, and when possible, lives as their affirmed gender in places where it is safe to do so.
  o The gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder) is not a symptom of another mental disorder.

Breast augmentation for transfeminine members may be considered MEDICALLY NECESSARY when ALL of the following candidate criteria are met:
• Age ≥ 18
• The member has been diagnosed with gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder), and meets ALL of the following indications:
  o The desire to live and be accepted as a member of another gender other than one’s assigned sex, typically accompanied by the desire to make the physical body as congruent as possible with the identified gender through surgery and hormone treatment.
  o The new gender identity has been present for at least 12 months.
  o The member has a consistent, stable gender identity that is well documented by their treating providers, and when possible, lives as their affirmed gender in places where it is safe to do so.
  o The gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder) is not a symptom of another mental disorder.

Genital Procedures and Electrolysis
Genital surgery for transmasculine, transfeminine or gender diverse members may be considered MEDICALLY NECESSARY when ALL of the following candidate criteria are met as documented by two treating clinicians:
• Age ≥ 18
• The member has been diagnosed with gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder), including meeting ALL of the following indications:
  o The desire to live and be accepted as a member of another gender other than one’s assigned sex, typically accompanied by the desire to make the physical body as congruent as possible with the identified gender through surgery and hormone treatment.
  o The new gender identity has been present for at least 12 months.
  o The member has a consistent, stable gender identity that is well documented by their treating providers, and when possible, lives as their affirmed gender in places where it is safe to do so.
  o The gender dysphoria (ICD-10 codes F64.0-F64.9 gender identity disorder) is not a symptom of another mental disorder.

Electrolysis or laser hair removal performed by a licensed provider may be considered MEDICALLY NECESSARY for the removal of hair on skin being used for genital gender affirmation surgery.

Electrolysis or laser hair removal for any other part of the body for any other indication is not covered.
Surgical Services for Adolescents
Members < 18 years of age will be considered on a case-by-case basis.

In addition to meeting all of the above criteria, providers requesting surgery for members < 18 will need to provide documentation supporting all of the following:
• The member has been evaluated for safety.
• The member has adequate home support.
• The member has realistic expectations regarding the possibilities and limitations of surgery and a full understanding of the long-term consequences of surgical procedures.
• The member has been assessed for any co-existing mental health concerns and is not requesting surgery as an initial response to gender dysphoric puberty.

Surgical Revisions
Reconstructive surgery following gender affirmation surgery (including facial surgery) may be considered MEDICALLY NECESSARY when it is performed to:
• Correct complications resulting from the initial surgery, OR
• Correct functional impairment resulting from initial surgery.

Reconstructive surgery following gender affirmation surgery is NOT MEDICALLY NECESSARY to reverse natural signs of aging or if the member is not satisfied with the surgical result.

Any services performed to reverse gender affirmation surgery are considered INVESTIGATIONAL.

Not Medically Necessary/Not Covered Services
The following procedures are considered INVESTIGATIONAL and are not covered:
• Breast lift
• Lip enhancement
• Neck lift
• Dermabrasion
• Chemical peel
• Hair transplant
• Electrolysis (except for genital surgery as noted above)
• Vocal cord surgery.

Speech Therapy / Voice Training
Feminizing or masculinizing speech therapy and/or voice training services for transgender and gender diverse members with or without additional health diagnoses are covered services.

Prior Authorization Information
Inpatient
• For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
• For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior authorization is required for surgical services only.*</td>
</tr>
</tbody>
</table>
Commercial PPO and Indemnity  
Prior authorization is required for surgical services only.*

Medicare HMO BlueSM  
Prior authorization is required for surgical services, speech therapy and/or voice training services only.*

Medicare PPO BlueSM  
Prior authorization is not required.

*Prior Authorization Request Form: Gender Affirming Services (Transgender Services)  
The relevant form must be completed and faxed to: Medical and Surgical: 1-888-282-0780; Medicare Advantage: 1-800-447-2994; BCBSMA Employees: 617-246-4299  
Click here for:  
• Prior Authorization Request for Gender Affirming Services (Transgender Services) Form #901  
• Prior Authorization Request for Electrolysis for Gender Affirming Services (Transgender Services) Form #902

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2020</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>11/2019</td>
<td>Clarified coding information.</td>
</tr>
</tbody>
</table>
| 9/2019   | Policy revised. Effective 9/1/2019  
To include not medically necessary statements on breast lift.  
To include new medically necessary statements for feminizing or masculinizing speech therapy and/or voice training services.  
To indicate that prior authorization is required for Medicare HMO.  
Policy clarified. Effective 9/1/2019  
To reflect current terminology i.e. gender identity, gender diverse.  
To include bicalutamide for gender affirming hormone therapy  
Medically necessary statement on electrolysis or laser hair removal edited to remove skin graft donor site.  
2/2019   | Policy updated to include new medically necessary statements on hormone therapy/puberty blockers; gender-affirming hormone therapy; surgical services for adolescents; supportive behavioral health services. Effective 2/1/2019.  
Revised policy statements on facial procedures; chest procedures; genital procedures and electrolysis. Effective 2/1/2019.  
Not medically necessary statements revised to include vocal cord surgery as investigational procedure. Effective 2/1/2019.  
Speech therapy/voice training feminizing or masculinizing speech therapy added as not covered. Effective 2/1/2019.  
New references added.  
10/2018  | Clarified coding information.                                                              |
4/2017   | Clarified coding information.                                                              |
| 2/2017   | Clarified coding information.                                                              |
10/2015  | Clarified coding information.                                                              |
<p>| 9/2015   | Clarified coding information.                                                              |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/2015</td>
<td>Ongoing coverage on cryopreservation for transgender members added. Statement transferred from medical policy #086, Infertility Diagnosis and Treatment.</td>
</tr>
<tr>
<td>10/2014</td>
<td>Coding information clarified.</td>
</tr>
<tr>
<td>9/2014</td>
<td>Coding information clarified.</td>
</tr>
<tr>
<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.</td>
</tr>
<tr>
<td>4/2014</td>
<td>Language on benefit riders added.</td>
</tr>
<tr>
<td>4/2014</td>
<td>Coding information clarified.</td>
</tr>
</tbody>
</table>

**Information Pertaining to All Blue Cross Blue Shield Medical Policies**

Click on any of the following terms to access the relevant information:

- [Medical Policy Terms of Use](#)
- [Managed Care Guidelines](#)
- [Indemnity/PPO Guidelines](#)
- [Clinical Exception Process](#)
- [Medical Technology Assessment Guidelines](#)

**References**


31. World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association). WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Minneapolis, MN: World Professional Association for Transgender Health. 7th ed. Available at: www.wpath.org


diagnosis codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes / HCPCS Codes / ICD Codes
The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria on pp. 1-2 MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

### CPT Codes

#### Male to Female Surgery

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17380</td>
<td>Electrolysis epilation, each 30 minutes</td>
</tr>
<tr>
<td>19325</td>
<td>Mammoplasty, augmentation; with prosthetic implant</td>
</tr>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
</tr>
<tr>
<td>19357</td>
<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
</tr>
<tr>
<td>19380</td>
<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
</tr>
<tr>
<td>53410</td>
<td>Urethroplasty, 1-stage reconstruction of male anterior urethra</td>
</tr>
<tr>
<td>53420</td>
<td>Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage</td>
</tr>
<tr>
<td>53425</td>
<td>Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage</td>
</tr>
<tr>
<td>54120</td>
<td>Amputation of penis; partial</td>
</tr>
<tr>
<td>54125</td>
<td>Amputation of penis; complete</td>
</tr>
<tr>
<td>54300</td>
<td>Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra</td>
</tr>
<tr>
<td>54520</td>
<td>Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach</td>
</tr>
<tr>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy</td>
</tr>
<tr>
<td>55970</td>
<td>Intersex surgery; male to female</td>
</tr>
<tr>
<td>56800</td>
<td>Plastic repair of introitus</td>
</tr>
<tr>
<td>56805</td>
<td>Clitoroplasty for intersex state</td>
</tr>
<tr>
<td>57291</td>
<td>Construction of artificial vagina; without graft</td>
</tr>
<tr>
<td>57292</td>
<td>Construction of artificial vagina; with graft</td>
</tr>
<tr>
<td>57335</td>
<td>Vaginoplasty for intersex state</td>
</tr>
</tbody>
</table>

#### Facial Surgery (Male or Female)

##### Brow Reconstruction

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21137</td>
<td>Reduction forehead; contouring only</td>
</tr>
<tr>
<td>21138</td>
<td>Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)</td>
</tr>
<tr>
<td>21139</td>
<td>Reduction forehead; contouring and setback of anterior frontal sinus wall</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</td>
</tr>
<tr>
<td>21209</td>
<td>Osteoplasty, facial bones; reduction</td>
</tr>
</tbody>
</table>

##### Brow Lift

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
</tbody>
</table>

##### Blepharoplasty

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT codes</td>
<td>Code Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive herniated fat pad</td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
</tr>
</tbody>
</table>

### Rhinoplasty

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30400</td>
<td>Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30410</td>
<td>Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30420</td>
<td>Rhinoplasty, primary; including major septal repair</td>
</tr>
</tbody>
</table>

### Cheek Augmentation

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21270</td>
<td>Malar augmentation, prosthetic material</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</td>
</tr>
<tr>
<td>21209</td>
<td>Osteoplasty, facial bones; reduction</td>
</tr>
</tbody>
</table>

### Jaw Reconstruction

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21125</td>
<td>Augmentation, mandibular body or angle; prosthetic material</td>
</tr>
<tr>
<td>21127</td>
<td>Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</td>
</tr>
<tr>
<td>21209</td>
<td>Osteoplasty, facial bones; reduction</td>
</tr>
</tbody>
</table>

### Chin Reconstruction

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21120</td>
<td>Genioplasty; augmentation (autograft, allograft, prosthetic material)</td>
</tr>
<tr>
<td>21121</td>
<td>Genioplasty; sliding osteotomy, single piece</td>
</tr>
<tr>
<td>21122</td>
<td>Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)</td>
</tr>
<tr>
<td>21123</td>
<td>Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</td>
</tr>
<tr>
<td>21209</td>
<td>Osteoplasty, facial bones; reduction</td>
</tr>
</tbody>
</table>

### Face Lift

The following codes are covered when required as part of a medically necessary facial feminization procedure.

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15824</td>
<td>Rhytidectomy; forehead</td>
</tr>
<tr>
<td>15825</td>
<td>Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)</td>
</tr>
<tr>
<td>15826</td>
<td>Rhytidectomy; glabellar frown lines</td>
</tr>
<tr>
<td>15828</td>
<td>Rhytidectomy; cheek, chin, and neck</td>
</tr>
</tbody>
</table>

### Liposuction

The following codes are covered when required as part of a medically necessary facial feminization procedure.

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15876</td>
<td>Suction assisted lipectomy; head and neck</td>
</tr>
</tbody>
</table>

### Trachea Shave

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
</table>

Female to Male Surgery

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19303</td>
<td>Mastectomy, simple, complete</td>
</tr>
<tr>
<td>19316</td>
<td>Mastopexy</td>
</tr>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
</tr>
<tr>
<td>53430</td>
<td>Urethroplasty, reconstruction of female urethra</td>
</tr>
<tr>
<td>54660</td>
<td>Insertion testicular prosthesis</td>
</tr>
<tr>
<td>55175</td>
<td>Scrotoplasty; simple</td>
</tr>
<tr>
<td>55180</td>
<td>Scrotoplasty; complex</td>
</tr>
<tr>
<td>55980</td>
<td>Intersex surgery; female to male</td>
</tr>
<tr>
<td>56620</td>
<td>Vulvectomy; simple</td>
</tr>
<tr>
<td>56625</td>
<td>Vulvectomy; complete</td>
</tr>
<tr>
<td>56800</td>
<td>Plastic repair of introitus</td>
</tr>
<tr>
<td>56805</td>
<td>Clitoroplasty for intersex state</td>
</tr>
<tr>
<td>56810</td>
<td>Perineoplasty, repair of perineum, nonobstetrical</td>
</tr>
<tr>
<td>57110</td>
<td>Vaginectomy; complete removal of vaginal wall</td>
</tr>
<tr>
<td>57111</td>
<td>Vaginectomy; with removal of paravaginal tissue (radical vaginectomy)</td>
</tr>
<tr>
<td>58150</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58180</td>
<td>Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250 gms or less</td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)</td>
</tr>
<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;</td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
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<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;</td>
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<tr>
<td>58552</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)</td>
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<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g</td>
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<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
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<td>58572</td>
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<tr>
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<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
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The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT code above if above medical necessity criteria on pp. 1-2 are met:

ICD-10 Diagnosis Codes
### ICD-10-CM Diagnosis codes:

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<tr>
<th>Code</th>
<th>Description</th>
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<td>Transsexualism</td>
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<td>Gender identity disorder in adolescence and adulthood</td>
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<td>Gender identity disorder of childhood</td>
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<td>Other identity disorders</td>
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<td>F64.9</td>
<td>Gender identity disorder, unspecified</td>
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The above **medical necessity criteria** on pp. 2-7 MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

### ICD-10 Procedure Codes

#### Male to Female Surgery

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<tr>
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<th>Code Description</th>
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<tr>
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<tr>
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Facial Surgery (Male or Female)

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**Female to Male Surgery**

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**Endnotes**

1 Based on expert opinion