

Clinical Policy: Gender-Affirming Procedures

Reference Number: OR.CP.MP.95

Date of Last Revision:1/26

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Description

Gender-affirming treatment describes “a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual’s gender identity and the individual’s sex assignment at birth”.² Services for gender affirmation most often include hormone treatment, counseling, psychotherapy, complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate, genital reconstruction, facial hair removal, and certain facial plastic reconstruction. Not every individual will require each intervention, so necessity needs to be considered on an individualized basis. The criteria in this policy outline the medical necessity criteria for gender-affirming medical and surgical treatment (GAMST).

Policy/Criteria

I. It is the policy of Trillium Community Health Plan that gender-affirming surgeries are considered **medically necessary** for members when diagnosed with gender dysphoria or gender incongruence per section A. and when meeting the eligibility criteria in section B.

Note: Intersex individuals are not subject to the criteria in this policy.

A. Gender Dysphoria or Gender Incongruence Criteria:

1. Marked and sustained incongruence between the member’s experienced/expressed gender and assigned gender, as indicated by *two or more* of the following:
 - a. Marked incongruence between the member’s experienced/expressed gender and primary and/or secondary sex characteristics;
 - b. 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;
 - c. A strong desire for the primary and/or secondary sex characteristics of the other gender;
 - d. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender);
 - e. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender);
 - f. 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);
 - g. The condition is associated with impairment in social, occupational, or other important areas of functioning;

B. Eligibility criteria, all of the following:

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1. Capacity to make a fully informed decision (including, but not limited to, awareness of the potential effects of treatment on fertility) and to consent for treatment;
2. If significant medical or mental health concerns are present, they are reasonably well controlled;
3. Other possible causes of apparent gender dysphoria, gender incongruence, or gender diversity have been identified and excluded;
4. One of the following:
 - a. For members ≥ 18 years, all of the following:
 - i. Assessment for GAMST from a provider who meets both of the following:
 - a) Has experience in or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider);
 - b) Is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated;
 - ii. The documented assessment for GAMST meets all of the following:
 - a) Identifies any mental or physical health conditions that could negatively impact the outcome of GAMST, with risks and benefits discussed;
 - b) Notes the member's capacity to understand the effect of GAMST on reproduction and includes a discussion of reproductive options with the member prior to the initiation of GAMST;
 - iii. Member remains stable on their gender affirming hormonal treatment regime (which may include at least six months of hormone treatment or longer if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated);
 - b. For members ages 15 to 17 years of age years all of the following:
 - i. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
 - ii. Has reached Tanner stage 2;
 - iii. Member has been informed of the reproductive effects of GAMST, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development;
 - iv. Member has completed a minimum of 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;
 - v. Assessment for GAMST from a provider who meets both of the following:
 - a) Has experience in or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity (e.g., mental health professional,

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- general medical practitioner, nurse, or other qualified health care provider);
- b) Is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated;
- C. Gender-affirming surgeries considered **medically necessary** when meeting above criteria and additional criteria as listed below for specific procedures:
1. For members 15 to 17 years of age, any of the following:
 - a. One of the following procedures is requested:
 - i. Penectomy;
 - ii. Urethroplasty;
 - iii. Mammoplasty;
 - iv. Mastectomy, and the member has been assessed for risk factors associated with breast cancer;
 - v. Clitoroplasty;
 - vi. Vulvoplasty;
 - vii. Labiaplasty;
 - viii. Vaginectomy;
 - ix. Vulvectomy;
 - x. Scrotoplasty;
 - xi. Testicular prosthesis;
 - b. Twelve months of hormone therapy has been administered (unless hormone therapy is not desired or is medically contraindicated) and one of the following procedures has been requested:
 - i. Breast augmentation, and the member has been assessed for risk factors associated with breast cancer;
 - ii. Phalloplasty;
 - iii. Metoidioplasty;
 - iv. Vaginoplasty;
 - v. Gonadectomy (i.e., hysterectomy, orchiectomy);
 - c. A cosmetic service deemed a **medically necessary** procedure and prescribed by a physical or behavioral health care provider as gender-affirming treatment, including but not limited to:
 - i. Tracheal shave;
 - ii. Hair electrolysis;
 - iii. Facial feminization surgery or other facial gender-affirming treatment;
 - iv. Revisions to prior forms of gender-affirming treatment;
 - v. Any combination of gender-affirming treatment procedures;
 2. For members ≥ 18 years of age, any of the following:
 - a. One of the following procedures is requested:
 - i. Penectomy;
 - ii. Urethroplasty;
 - iii. Mammoplasty;

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- iv. Mastectomy, and the member has been assessed for risk factors associated with breast cancer;
 - v. Clitoroplasty;
 - vi. Vulvoplasty;
 - vii. Labiaplasty;
 - viii. Vaginectomy;
 - ix. Vulvectomy;
 - x. Scrotoplasty;
 - xi. Testicular prosthesis;
 - xii. Breast augmentation, and the member has been assessed for risk factors associated with breast cancer;
 - xiii. Phalloplasty;
 - xiv. Metoidioplasty;
 - xv. Vaginoplasty;
 - xvi. Gonadectomy (i.e., hysterectomy, salpingo-oophorectomy, orchiectomy; at least six months of hormone therapy may be considered prior to procedure, as appropriate for the member's goals);
- b. A cosmetic service deemed a **medically necessary** procedure and prescribed by a physical or behavioral health care provider as gender-affirming treatment, including but not limited to:
- i. Tracheal shave;
 - ii. Hair electrolysis;
 - iii. Facial feminization surgery or other facial gender-affirming treatment;
 - iv. Revisions to prior forms of gender-affirming treatment;
 - v. Any combination of gender-affirming treatment procedures.

Background

The World Professional Association for Transgender Health (WPATH) is an international professional society dedicated to promoting the highest level of evidence-based principles for transgender and gender diverse (TGD) individuals.⁸ Gender identity is a person's deepest inner sense of being female or male, which for many is established by the age of two through three years. *Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.⁹ *Gender dysphoria* refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).^{9,10} Per WPATH, the focus of gender dysphoria is not on the individual's gender identity, but on any of the distress or discomfort related to being TGD.⁸ WPATH states that gender incongruence is considered a condition with a focus on the TGD person's experienced identity and any need for gender-affirming treatment that arises from this identity.⁸

Treatment to assist people with gender dysphoria is available and can help to find the gender identity and role that is comfortable for them. Treatment is very individualized and may or may

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not involve gender-affirming surgery or body modification. Treatment options include changes in gender expression and role; hormone therapy to feminize or masculinize the body; surgery to change primary and/or secondary sex characteristics; and psychotherapy. Many people who receive treatment for gender dysphoria will find a gender role and expression that is comfortable for them, regardless of whether they differ from the sex assigned to them at birth.

WPATH's Standards of Care (SOC) are a series of flexible guidelines for clinical practice published by the society and are based on evidence and expert consensus. Version 8 of WPATH's SOC were published in 2022, and these guidelines offer clinical guidance to health care professionals caring for TGD people and are intended to be adaptable to meet the diverse health care needs of this population.⁸

Per Oregon State law 109.640; (4) (a) A minor 15 years of age or older may give consent, without the consent of a parent or guardian to hospital care, medical or surgical diagnosis or treatment by a physician licensed by the Oregon Medical Board or a naturopathic physician licensed under ORS chapter 685.³ Oregon also passed House Bill 2002, which expands covered gender-affirming care and services.²

WPATH recommends that the assessment for gender-affirming medical and surgical treatment (GAMST) in individuals < 18 years old be completed by a provider who is licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution. The provider(s) working with gender diverse adolescents should additionally meet all of the following⁸:

1. Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum;
2. Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span;
3. Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents;
4. Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families;
5. Complete a comprehensive biopsychosocial assessment of the adolescent member presenting with gender identity-related concerns and seek medical/surgical transition-related care in a collaborative and supportive manner;
6. Maintain an ongoing relationship with the gender diverse and transgender adolescent member and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care;
7. Involve parent(s)/guardian(s) in the GAMST assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible;
8. Involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related

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surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

WPATH recommends that the assessment for GAMST in adults ≥ 18 years of age be completed by a provider who is licensed by their statutory body and hold, at a minimum, a master’s degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider). The provider(s) working with gender diverse adults should additionally meet all of the following⁸:

1. Identify co-existing mental health or other psychosocial concerns, distinguishing these from gender dysphoria, incongruence, and diversity;
2. Assess capacity to consent for treatment (capacity to consent is required for GAMST assessment);
3. Have experience or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity and is able to liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required;
4. Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments;
5. Ensure any mental or physical health conditions that could negatively impact the outcome of GAMSTs are assessed, with risks and benefits discussed, before a decision is made regarding treatment;
6. Assess the member’s capacity to understand the effect of GAMST on reproduction and discuss reproduction options with the member prior to the initiation of GAMST;
7. Assess and discuss the role of social transition with the member requesting GAMST.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes that may be considered part of gender-affirming surgery.

This code list does not indicate if a procedure is or is not considered medically necessary.

CPT® Codes	Description
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
11920-11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin
11950 through 11954	Subcutaneous injection of filling material (e.g., collagen)

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CPT® Codes	Description
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
11981	Insertion, drug-delivery implant (i.e., bioresorbable, biodegradable, non-biodegradable)
11982	Removal, non-biodegradable drug delivery implant.
11983	Removal with reinsertion, non-biodegradable drug delivery implant
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm,
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate 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) of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50cc injectate, or part thereof (List separately in addition to code for primary procedure): CPT code 15772 is the add-on code for autologous fat grafting to the trunk, breasts, extremities, or scalp for each additional 50cc of injectate
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
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)

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CPT® Codes	Description
15820 through 15823	Blepharoplasty
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 through 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876 through 15879	Suction assisted lipectomy
17110	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
20912	Cartilage graft; nasal septum
21025	Excision of bone (e.g., for osteomyelitis or bone abscess); mandible
21026	Excision of bone (e.g., for osteomyelitis or bone abscess); facial bone(s)
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)

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CPT® Codes	Description
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
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., 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) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
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 (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
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
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)

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CPT® Codes	Description
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
31750	Tracheoplasty; cervical
40654	Repair lip, full thickness; over one-half vertical height, or complex
51040	Cystostomy, cystotomy with drainage
51102	Aspiration of bladder; with insertion of suprapubic catheter
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
53010	Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
53020	Meatotomy, cutting of meatus (separate procedure); except infant
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johanssen 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 female urethra
53450	Urethromeatoplasty, with mucosal advancement
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
53520	Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)
54120	Amputation of penis; partial
54125	Amputation of penis; complete
54348	Repair of hypospadias complication(s) (i.e., fistula, stricture, diverticula); requiring extensive dissection, and urethroplasty with flap, patch or tubed graft (including urinary diversion, when performed)
54352	Revision of prior hypospadias repair requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts
54360	Plastic operation on penis to correct angulation
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)

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CPT® Codes	Description
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54440	Plastic operation of penis for injury
54520	Orchiectomy, simple (including subcapsular) with or without testicular prosthesis, scrotal or inguinal approach
54530	Orchiectomy, radical, for tumor; inguinal approach
54660	Insertion testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55120	Removal of foreign body in scrotum
55150	Resection of scrotum
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
56620	Vulvectomy simple; partial
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 vaginal wall

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CPT® Codes	Description
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57120	Colpocleisis (Le Fort type)
57291	Construction artificial vagina; without graft
57292	Construction artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58150	Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (e.g., 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)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
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)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
58353	Endometrial ablation, thermal, without hysteroscopic guidance

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CPT® Codes	Description
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)
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	Laparoscopy surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58740	Lysis of adhesions (salpingolysis, ovariolysis)
58940	Oophorectomy, partial or total, unilateral or bilateral
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64859	Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure)
64905	Nerve pedicle transfer; first stage
64910	Nerve repair; with synthetic conduit or vein allograft (e.g., nerve tube), each nerve
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
90785	Interactive complexity (List separately in addition to the code for primary procedure)
90832	Psychotherapy, 30 minutes with patient

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CPT® Codes	Description
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment

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CPT® Codes	Description
	instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes

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CPT® Codes	Description
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service)
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

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CPT® Codes	Description
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

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CPT® Codes	Description
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

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CPT® Codes	Description
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

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CPT® Codes	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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Gender-Affirming Procedures

CPT® Codes	Description
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99374	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in

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CPT® Codes	Description
	patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99375	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)

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Gender-Affirming Procedures

CPT® Codes	Description
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years

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CPT® Codes	Description
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

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CPT® Codes	Description
99424	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
99425	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99426	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.
99427	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99429	Unlisted preventive medicine service

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CPT® Codes	Description
99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

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CPT® Codes	Description
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge

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CPT® Codes	Description
99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient
99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)

HCPCS Codes	Description
A9282	Wig, any type each
C1789	Prosthesis, breast (implantable)
C7903	Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service
G0017	Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the nonfacility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes
G0018	Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the nonfacility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (list separately in addition to code for primary service)

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HCPCS Codes	Description
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner, 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:
G0022	Community health integration services, each additional 30 minutes per calendar month (list separately in addition to G0019)
G0023	Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator, 60 minutes per calendar month, in the following activities:
G0024	Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to G0023)
G0068	Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 min
G0140	Principal illness navigation-peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist, 60 minutes per calendar month, in the following activities:
G0146	Principal illness navigation-peer support, additional 30 minutes per calendar month (list separately in addition to G0140)
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0248	Demonstration, prior to initiation of home INR monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient's ability to perform testing and report results
G0249	Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include four tests

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HCPCS Codes	Description
G0250	Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include four tests
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99417). (Do not report G0318 for any time unit less than 15 minutes)
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (These services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0463	Hospital outpatient clinic visit for assessment and management of a patient
G0466	Federally qualified health center (FQHC) visit, new patient
G0467	Federally qualified health center (FQHC) visit, established patient
G0469	Federally qualified health center (FQHC) visit, mental health, new patient
G0470	Federally qualified health center (FQHC) visit, mental health, established patient

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HCPCS Codes	Description
G0490	Face-to-face home health nursing visit by a rural health clinic (RHC) or federally qualified health center (FQHC) in an area with a shortage of home health agencies; (services limited to RN or LPN only)
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
G2252	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care e.g., physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Requires initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded)
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002. When using G3003, 15 minutes must be met or exceeded)
G0534	Coordinated care and/or referral services, such as to adequate and accessible community resources to address unmet health-related social needs, including harm reduction interventions and recovery support services a patient needs and wishes to pursue, which significantly limit the ability to diagnose or treat an opioid use disorder; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0535	Patient navigational services, provided directly or by referral; including helping the patient to navigate health systems and identify care providers and supportive services, to build patient self advocacy and communication skills with care

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HCPCS Codes	Description
	providers, and to promote patient-driven action plans and goals; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0539	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (use G0542 in conjunction with G0541)
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
G0544	Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month
G0546	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review
G0547	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review

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HCPCS Codes	Description
G0548	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review
G0549	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review
G0550	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time
G0551	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes
G0556	Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], or fewer, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:
G0557	Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:
G0558	Advanced primary care management services for a patient that is a Qualified Medicare Beneficiary (QMB) with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and

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HCPCS Codes	Description
	serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:
G0559	Postoperative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
G3001	Administration and supply of tositumomab, 450 mg
H0004	Behavioral health counseling and therapy, per 15 minutes
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0032	Mental health service plan development by nonphysician
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0038	Self-help/peer services, per 15 minutes
H0052	Missing and murdered indigenous persons (MMIP) mental health and clinical care
H0053	Historical trauma (HT) mental health and clinical care for indigenous persons
H2010	Comprehensive medication services, per 15 minutes
H2014	Skills training and development, per 15 minutes
H2027	Psychoeducational service, per 15 minutes
H2032	Activity therapy, per 15 minutes
H2033	Multisystemic therapy for juveniles, per 15 minutes
H2038	Skills training and development, per diem
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes
S9484	Crisis intervention mental health services, per hour

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HCPCS Codes	Description
S9563	Home injectable therapy, immunotherapy, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	01/24	02/24
Annual review. Minor rewording with no clinical significance. Added CPT codes 11920 – 11922; 53400, 53405, 58180, 97550 – 97552, 99437 - 99439; and HCPCS codes G9037 and G9038. Removed CPT codes 11960, 11970, 14000, 14001, 14040, 14041, 15100, 15101, 15120, 15121, 15200, 15570, 15574, 15600, 15620, 15757, 15758, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15836, 15837, 15838, 21210, 31599, 31899; 58200, 58210, 58240, 58999, 64892, 64896, 90845. References reviewed and updated.	12/24	02/25
Annual review. Removed CPT codes 99441, 99442, 99443, 58999; HCPCS codes G0017, G0071, G0248, G0425, G0511, G2012, G9037, G9038. Added CPT codes 15777, 15878, 53460, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016 and HCPCS codes A9282, G0017, G0248, G0425, G0534, G0535, G0539, G0540, G054, G0542, G0543, G0544, G0546, G0547, G0548, G0549, G0550, G0551, G0556, G0557, G0558, G0559, G2214, G2251, G3001, H0052, H0053. References reviewed and updated.	1/26	02/26

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and

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accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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