



Keystone First

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

Clinical Policy Title: Gender confirmation treatment (medical and surgical)

Clinical Policy Number: 17.03.01

Effective Date: January 1, 2015
Initial Review Date: July 16, 2014
Most Recent Review Date: April 2016
Next Review Date: November 2017

Related Policies:

None.

Policy contains:

- Transgender reassignment.
- Gender dysphoria.
- Gender confirmation surgery (GCS).

ABOUT THIS POLICY: Keystone First has developed clinical policies to assist with making coverage determinations. Keystone First's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by Keystone First when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Keystone First's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Keystone First's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First will update its clinical policies as necessary. Keystone First's clinical policies are not guarantees of payment.

Coverage policy

Keystone First considers the use of medical and surgical transgender confirmation to be clinically proven and, therefore, medically necessary when the following criteria are met:

I. Criteria:

- A. Member is an adult, age 18 years or older, or documented as an emancipated adolescent, or has documentation of appropriate consent from parent or guardian.
- B. Member has the capacity to make fully informed decisions and consent for treatment.
- C. Member has established diagnosis of persistent, well-documented Gender Confirmation Surgery (GCS) as defined in the DSM-5 TR criteria of GD in adolescents and adults:
 1. Strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
 2. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the dysphoria is manifested

by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

3. The dysphoria is not concurrent with a physical intersex condition.
 4. The dysphoria causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- D. The diagnosis has been made and documented by a professional appropriately trained in transgender medicine. (See glossary for definition of “appropriately trained in transgender medicine.”)
 - E. Member desires to live and be accepted as a person of the opposite sex, usually accompanied by the wish to make his/her body conform as much as possible with the preferred sex through surgery and hormone treatment.
 - F. Has had real-life experience of at least 12 months.
 - G. GD is not a symptom of another mental disorder.

II. Hormone therapy:

- A. Member has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician with documentation of member’s compliance and the type, frequency and route of administration. For mastectomy and creation of a male chest in female to male patient hormone therapy is not a prerequisite. (WPATH p59-60)

**This is not a requirement for mastectomy in female to male patients.

Note: Hormonal gender confirmation does not refer to the administration of hormones for the purpose of medical care or research conducted for the treatment or study of non-gender dysphoric medical conditions (i.e., aplastic anemia, impotence, cancer).

III. Psychotherapy:

- A. Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or mental health practitioner.
- B. If significant medical or mental health issues are present, documentation is required indicating they are reasonably well controlled.
- C. If the member is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), documentation must indicate an effort has been made to improve these conditions with psychotropic medications and/or psychotherapy before GCS is considered.

IV. Referrals:

- A. Three referrals are necessary:

1. One referral must be from the member's medical provider or surgical provider who will be rendering longitudinal care.
2. Two referrals for genital surgery or one referral for breast or chest surgery; one of which must be from a qualified mental health professional who has independently assessed the individual. (WPATH, p27)
3. If the first mental health referral is from the member's psychotherapist, the second referral should be from an independent evaluator.
4. At least one of the mental health professionals submitting a letter must be appropriately trained in transgender medicine. (See glossary.)

B. The referral letters must include:

1. Agreement to the proposed Gender Confirmation Surgery (GCS) within three months of the prior authorization request.
2. Documentation that there are no contraindications to the planned surgery.

C. Format for referral letters/letters of qualification should include:

- Member's general identifying characteristics.
- Results of the member's psychosocial assessment, including any diagnoses.
- Duration of the mental health professional's relationship with the member, including the type of evaluation and therapy or counseling to date.
- Explanation that the criteria for surgery have been met and a brief description of the clinical rationale for supporting the member's request for surgery.
- A statement that informed consent has been obtained from the member.
- A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

V. Surgical procedures for transgender confirmation — Specific coverage by CPT code is listed below.

A. The following surgeries required for male-to-female members are medically necessary if all the criteria listed in sections I. through V. are met:

1. Genital surgery and breast surgery:

- a. Penectomy.
- b. Orchiectomy.
- c. Vaginoplasty.
- d. Clitoroplasty.
- e. Labiaplasty.
- f. Mammoplasty, augmentation.
- g. Nipple/areola reconstruction.

B. The following surgeries required for female-to-male members are medically necessary if all the criteria listed in sections I. through V. are met:

1. Hysterectomy.
2. Salpingo-oophorectomy.
3. Vaginectomy.
4. Phalloplasty.
5. Metoidioplasty.
6. Scrotoplasty.
7. Urethroplasty.
8. Testicular prostheses implantation.
9. Mastectomy.
10. Reduction mammoplasty.
11. Vulvectomy.

Limitations:

All other uses of medical and surgical transgender confirmation are not medically necessary.

A. Members should be ruled out for surgery if any of the following are applicable:

1. Psychotic disorder (e.g., schizophrenia, psychotic disorder not otherwise specified or schizoaffective disorder).

B. Exclusionary criteria — Services should not be covered under the following conditions:

1. Failure to meet one or more of the criteria for coverage stated in sections I through V in this policy.
2. Reversal of GCS or any medical procedure covered under original GCS.
3. Cosmetic procedures used to improve the gender-specific appearance of a person who has undergone or is planning to undergo GCS is not covered:
 - a. Reduction thyroid chondroplasty.
 - b. Liposuction.
 - c. Rhinoplasty.
 - d. Facial bone reconstruction.
 - e. Face lift.
 - f. Blepharoplasty.
 - g. Hair removal.
 - h. Brow lift.
 - i. Lip reduction/enhancement.
 - j. Chin augmentation.
 - k. Facial bone reduction.
 - l. Laryngoplasty.
4. Procedures designed to preserve fertility as part of GCS:
 - a. These include but are not limited to the procurement, cryopreservation, thawing or storage of sperm, oocytes, ovaries or testicular tissue.

Alternative covered services:

None.

Background

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex confirmation to facilitate a physical change from male to female (MTF) or female to male (FTM) as completely as possible (e.g., Green and Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87 percent of MTF patients to 97 percent of FTM patients (Green and Fleming, 1990), and regrets were extremely rare (1 percent – 1.5 percent of MTF patients and <1 percent of FTM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting and Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their bodies. For others, changes in gender role and expression are sufficient to alleviate gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender and gender-nonconforming individuals has come of age — many of whom have benefitted from different therapeutic approaches — they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles and expressions. Some individuals describe themselves not as gender-nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves to be either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender or genderqueer, affirming their unique experiences that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins and King, 2006; Nestle, Wilchins, and Howell, 2002). They may not experience their process of identity affirmation as a “transition,” because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and

awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression comfortable for them.

In 1980, transsexualism was introduced in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) and 14 years later, in 1994, it was changed to Gender Identity Disorder (DSM-IV; supposed to be revised again in 2013 for DSM-5. Gender identity disorder (GID; previously called transsexualism) is defined as strong and persistent cross-gender identification with the patient's persistent discomfort with his or her sex and a sense of inappropriateness in the gender role of that sex (Diagnostic and Statistical Manual of Mental Disorders, fourth revision, text revision [DSM-IV-TR]). There is a wide array of terms that have been used to describe people within this group, including male to female (MTF), female to male (FTM), trans woman, trans man, transsexual, gender-affirmed female, gender-affirmed male and gender-affirmed person.

The disturbance is not concurrent with a physical intersex condition and causes clinical distress or impairment in social, occupational or other important areas of functioning. The trained mental health professional is obliged to find out if the patient fulfills the criteria of an irreversible gender transposition and if he or she will benefit from medical (hormonal and surgical) sex-confirmation treatment. If a patient has absolved 12 months of real-life experience and at least 12 months of continuous hormonal treatment, the indication for surgical sex confirmation may be given. Genital sex confirmation in male-to-female transsexuals includes vaginoplasty, preferably by inversion of penoscrotal skin flaps, clitoroplasty and vulvoplasty. The operation may be performed in one or two sessions. In contrast to genital confirmation in male-to-female patients, no operative standards are available in female-to-male subjects. Recently, neophallus creation from sensate-free forearm flaps has emerged as the most promising approach for those patients who want to have a neophallus. Other alternatives such as metoidioplasty or neophallus reconstruction from regional flaps exist, but are also accompanied by multiple possible complications and re-interventions. Best results are to be expected when using multidisciplinary teams of plastic surgeons, urologists, gynecologists and experts in sexual medicine in large-volume centers. Selvaggi et al. (2005) did an overview of gender identity disorder and surgical treatment for vaginoplasty in male-to-female transsexuals. Since 1978, the Harry Benjamin International Gender Dysphoria Association (in honor of Dr. Harry Benjamin, one of the first physicians who made many clinicians aware of the potential benefits of sex confirmation surgery) has played a major role in the research and treatment of gender identity disorder, publishing the Standards of Care for Gender Dysphoric Persons. The authors performed an overview of the terminology related to male-to-female gender identity disorder; the different theories regarding cause, epidemiology and treatment; the goals expected; and the surgical techniques available for gender confirmation surgery (GCS) in male-to-female GID, with advantages and disadvantages offered by each technique. Other feminizing nongenital operative interventions are also examined. Their conclusion was that this review describes recent etiopathogenetic theories and actual guidelines on the treatment of the gender identity disorder in male-to-female transsexuals; also the penile-scrotal skin flap technique is considered state-of-the-art for vaginoplasty in male-to-female transsexuals, whereas other techniques (rectosigmoid flap, local flaps and isolated skin grafts) should be considered only in secondary cases. As techniques in vaginoplasty

become more refined, more emphasis is being placed on aesthetic outcomes by both surgeons and patients.

Natal men and women differ in a number of metabolic variables associated with disease. Studies have shown after the administration of cross-sex hormones, changes may take place with respect to risk factors, such as homocysteine (associated with increased risk of cardiovascular disease and typically higher in natal men), distribution of fat and size of fat cells, insulin sensitivity, and blood pressure (Gooren and Giltay, 2013). Furthermore, cross-sex hormones put individuals at new risk for breast and prostate cancer. Therefore, a number of studies have explored health outcomes related to such risk factors. Some of the studies selected for detailed review reported that intermediate outcomes (risk factors) such as serum lipids and triglycerides, blood pressure, glucose and glycated hemoglobin (HbA1c) levels, liver enzyme levels, measures of renal function, and/or hematological measures were not elevated after hormone therapy when patients were compared either with general population norms or with transgender patients of the opposite sex (van Kesteren et al., 1997; Dittrich et al., 2005; Cohen-Kettenis et al., 2011; Wierckx et al., 2012; Khatchadourian et al., 2014). The discussion of evidence focuses on the actual health outcomes (diagnoses and events) associated with these risk factors plus bone health and obesity.

Searches

Keystone First searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality Guideline Clearinghouse and evidence-based practice centers.
- The Centers for Medicare & Medicaid Services.

Searches were conducted on June 27, 2014 using the terms “Gender Identity disorder” and “transsexualism, gender dysphoria” and gender confirmation surgery.

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

Findings

In evaluating earlier reviews and literature there are five individual surgical procedures for MTF GID: clitoroplasty, labiaplasty, orchidectomy, penectomy and vaginoplasty. Further evaluations were made of eight surgical procedures for FTM GID: hysterectomy, mastectomy, metoidioplasty, phalloplasty, salpingo-oophorectomy, scrotoplasty/placement of testicular prostheses, urethroplasty and vaginectomy. Increased prevalence and advances in surgical options available to patients requesting gender confirmation surgery have made greater patient options an important consideration for research. There remains a lack of systematic reviewing of the evidence, in particular of the individual surgical options available. Searches of six electronic databases (Applied Social Sciences Index and Abstracts [ASSIA], Cochrane Library [Wiley Online], Embase [Ovid Online], Medline [Ovid Online], Medline in Process [Ovid Online], Psycinfo) provided coverage of the biomedical, grey literature and current research. Eighty-two published papers (38 MTF; 44 FTM) met the inclusion criteria identified across the 13 surgical procedures. For individuals with MTF GID there was no evidence satisfying the inclusion criteria concerning labiaplasty, penectomy or orchidectomy procedures. A large amount of evidence was available concerning vaginoplasty and clitoroplasty procedures. For individuals with FTM GID, satisfactory outcomes were reported. These outcomes relate to the ability to perform sexual intercourse, achieve orgasm and void whilst standing. Some complications were reported for both MTF and FTM procedures. In conclusion, the evidence concerning gender confirmation surgery in people with both MTF and FTM GID has several limitations in terms of: (a) lack of controlled studies, (b) evidence not collecting data prospectively, (c) high loss to follow up and (d) lack of validated assessment measures. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence.

The prevalence of transsexual people has been determined to be as high as 1 in 11,900 males and 1 in 30,400 females. Standards of care for the psychological, endocrinological and surgical management of transsexual people have been proposed by the Harry Benjamin International Gender Dysphoria Association Inc. Specific management of hormonal regimens and long-term management, however, remain difficult to navigate. As a result, most physicians depend on observational and anecdotal reports to guide endocrine treatment.

Transgender confirmation surgery is the most important and effective treatment to correct the underlying problem of GID/Harry Benjamin Syndrome (see Glossary). The surgeon should be a urologist, gynecologist, plastic surgeon or general surgeon, and board-certified as such by a nationally known and reputable association. The surgeon should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons in this field must be willing to have their therapeutic skills reviewed by their peers. Willingness to undergo and cooperation with peer review are essential. This includes attendance at professional meetings where new ideas about techniques are presented.

Follow-up studies have shown undeniable beneficial effect of SRS on postoperative outcomes such as subjective well-being, cosmesis and sexual function (De Cuyper et al., 2005; Gifs and Brewaeys, 2007; Klein and Gorzalka, 2009; Pafafflin and Junge, 1998).

Cancer screening:

- Members who have vaginoplasty and mammoplasty surgeries should still have routine mammograms and gynecological exams.
- MTF members will still require periodic prostate screenings even if they have had some form of genital surgery.

Summary of clinical evidence:

Citation	Content, Methods, Recommendations
Lawrence (2003)	<p>Sex reassignment surgery (SRS)</p> <ul style="list-style-type: none"> • A survey of 232 male-to-female transsexuals at least one-year postoperative (operated on between 1994 and 2000 by one surgeon using a consistent technique) found patients were happy with their SRS results and SRS had greatly improved the quality of their lives. • None reported outright regret, and only a few expressed even occasional regret. Dissatisfaction was most strongly associated with unsatisfactory physical and functional results of surgery.
Lundstrom B, et al. (1984)	<p>Outcome of sex reassignment surgery:</p> <ul style="list-style-type: none"> • Three independent reviews of the world literature dealing with the outcome of SRS in GID are presented. In 10% – 15% of patients who undergo sex reassignment the results end up in a failure. • There are as many failures in the female-to-male group as in the male-to-female group. Optimal results from the surgical procedures are important for a successful outcome. • Relatively high age when first requesting sex reassignment may be regarded as a risk factor for poor outcome. Genuine transsexuals as a group seem to have a better prognosis for successful outcome of sex reassignment than a group of secondary transsexuals (i.e., transvestites and effeminate homosexuals). • On the other hand, secondary transsexuals do better than genuine transsexuals when sex reassignment is refused. It is stressed that great importance should be given to the differential diagnosis when evaluating gender dysphoric patients for sex reassignment.
de Vries et al. (2011).	<p>Effectiveness of pubertal suppression hormone therapy in adolescents.</p> <ul style="list-style-type: none"> • In a pre-test/post-test study of 70 adolescents who underwent approximately two years of pubertal suppression therapy, depression improved slightly, and overall emotional disturbance increased slightly and no change was observed in anger, anxiety or body image. • The authors thought it particularly noteworthy that the severity of GD, measured according to the standard measurements remained stable. Thus, the conclusion of the study was that pubertal suppression was a valuable strategy allowing exploration of treatment options for GD. • The validity of the findings is somewhat questionable, since baseline measurements were made on average one year before pubertal suppression began and the participants aged by approximately three years from baseline measurement to follow-up measurement. • The independent effects of mental and emotional maturation and the pubertal suppression therapy are unknown. The differences in improvement between biological males and females were small and generally nonsignificant, but the

	analysis did not adjust for the approximately one-year age difference between the two sexes. Evidence from this single small study is insufficient to support conclusions regarding pubertal suppression therapy.
Hayes (2013)	<p>Comparative effectiveness of hormone therapy alone vs. surgery (adults).</p> <ul style="list-style-type: none"> • The case series by Wierckx et al. (2014) (n = 352) found sexual desire was higher in those patients who had undergone SRS in addition to hormone therapy. • A smaller (n = 50) pre-test/post-test study found almost no change in sexual activity before and after SRS, whereas some improvements had been observed over the course of the preceding course of hormone therapy (Costantino et al., 2013). • Another study (n = 187; 120 in hormone therapy group) compared anxiety and depression scores between those who had and had not undergone SRS within the hormone therapy group; differences slightly favored SRS on one scale but showed no difference on two scales, whereas differences between the hormone therapy group and untreated individuals suggested consistently significant (statistically) although modest differences (Gómez-Gil et al., 2012). • The pre-test/post-test study by Heylens et al. (2014) (n = 57) observed a very small and nonsignificant worsening of psychological distress from a point three to six months after initiation of hormone therapy to assessment at one to 12 months after SRS. • Because of conflicting results across different outcome measures and the small quantity of data for each outcome, no conclusions regarding the comparative benefits of SRS and hormone therapy alone may be drawn.

Glossary

Active Substance Abuse—Has been defined by the World Health Organization a “ ‘maladaptive pattern of use indicated by ... continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use [or by] recurrent use in situations in which it is physically hazardous’ ”

http://www.who.int/substance_abuse/terminology/abuse/en/ Accessed August 6, 2015

Appropriately trained professional working with adults who present with gender dysphoria — The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A Master’s degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Disease* for diagnostic purposes.

3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.
4. Knowledge of gender nonconforming identities and expressions and the assessment and treatment of gender dysphoria.
5. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

Note: In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred. Mental health professionals new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria (The WPATH SOC-7, 2012).

Gender identity — The sense of being male or female that is usually in accord with, but sometimes opposed to, physical anatomy.

Gender dysphoria (GD) — A condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in the person's own gender (*Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition [DSM-V, 2013]*).

Gender identity disorder (GID) — Also transsexualism. A strong and persistent cross-gender identification (not concurrent with a physical intersex condition or simply a desire for any perceived cultural advantages of the other sex), marked by persistent discomfort with one's sex or a sense of inappropriateness in the gender role of that sex, and causing clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender confirmation surgery (GCS) — A treatment option for extreme cases of GD. GCS is not a single procedure, but part of a complex process involving multiple medical, psychiatric and surgical specialists working in conjunction with each other and the member to achieve successful behavioral and medical outcomes. Used interchangeably with sex reassignment surgery.

Genital surgical gender confirmation— Genital surgery that alters the morphology of the genitals to approximate the physical appearance of the genotypically other sex. The following surgical procedures (occurring in the absence of any diagnosable birth defect or other medically defined pathology [except gender dysphoria]) are included in this category:

1. Hysterectomy — removal of uterus.
2. Labiaplasty — creation of labia.
3. Mastectomy — removal the breast.
4. Metoidioplasty — creation of micro-penis, using the clitoris, inadequate for sexual penetration but sometimes allowing voiding while standing.
5. Oophorectomy — removal of ovaries.
6. Orchiectomy — removal of testicles.
7. Penectomy — removal of penis.
8. Phalloplasty — creation of penis, with or without urethra.
9. Reduction mammoplasty — reduction of breast size.
10. Salpingectomy — removal of fallopian tubes.
11. Scrotoplasty — creation of scrotum.
12. Testicular prostheses — implantation of artificial testes.
13. Urethroplasty — creation of urethra with the penis.
14. Vaginectomy — removal of vagina.
15. Vaginoplasty — creation of vagina.

Harry Benjamin Syndrome (HBS) — A medical condition caused by a biological variation in human sexual formation — an intersex condition— where the sex indicated by the phenotype and the genotype is opposite the morphological sex of the brain. Harry Benjamin Syndrome is named in honor of Dr. Harry Benjamin, a pioneer in the research of this condition. He was the physician who contributed much to the understanding and recognition of this condition. It was through his efforts the entire medical community came to understand HBS was unrelated to homosexuality.

Hormonal gender confirmation— The administration of androgens to genotypic and phenotypic females and estrogen or progesterone to genotypic or phenotypic males for the purpose of effecting somatic changes to more closely approximate the physical appearance of the genotypically other sex.

Intersex — A term used for people born with a reproductive or sexual anatomy and/or chromosome pattern that does not seem to fit typical definitions of male or female. Intersex conditions are also known as differences of sex development (DSD).These conditions can involve abnormalities of the external genitals, internal reproductive organs, sex chromosomes or sex-related hormones.

Nongenital surgical gender confirmation— Any other surgical procedures involving nongenital sites (e.g., breasts, skin, nose, throat, chin, cheeks, hips or waist) that may be performed to effect a more masculine appearance in a genetic female or a more feminine appearance in a genetic male.

Sexual orientation — A person’s attraction to members of the same sex and/or a different sex, usually defined as lesbian, gay, bisexual, heterosexual or asexual.

Primary sex characteristics — The genetically determined sex characteristics related to reproduction. The primary sex characteristics are the genital organs and their related hormones.

Real-life experience (RLE) — The act of fully adopting a new or evolving gender role or gender presentation in everyday life with the intention of achieving an experiential understanding of the familial, interpersonal, socioeconomic and legal consequences of gender transition.; also termed Transgender real-life experience.

Secondary sex characteristics — Various genetically transmitted physical or behavioral characteristics that appear in humans at puberty and differentiate between the sexes without having a direct reproductive function.

Trans men — Also female to male (FTM) people. People who were assigned female at birth but identify and live as men may use any of these terms to describe themselves.

Transsexuals — Individuals who have had or wish to have GCS, or who receive hormone therapy but do not wish to have GCS (nonoperative transsexuals), and live full-time in their new gender role.

Trans women — Also male to female (MTF) people. People who were assigned male at birth but identify and live as women may use any of these terms to describe themselves.

Transsexual surgery, also known as sex reassignment surgery, gender confirmation surgery or intersex surgery — The culmination of a series of procedures designed to change the anatomy of transsexual people to conform to their gender identity. Transsexual people are individuals with an overwhelming desire to change anatomic sex because of their fixed conviction that they are members of the opposite sex. For the male-to-female transsexual person, surgery entails castration, penectomy and vulva-vaginal construction. Surgery for the female-to-male transsexual person consists of bilateral mastectomy, hysterectomy and salpingo-oophorectomy which may be followed by phalloplasty and the insertion of testicular prostheses.

Related policies

Keystone First Utilization Management program description.

References

Professional society guidelines/other:

American Academy of Child and Adolescent Psychiatry (AACAP): *The Practice Parameter on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents* publ September 2012 (Adelson and AACAP,2012).

Committee on Health Care for Underserved Women. Committee Opinion no. 512: health care for transgender individuals. *Obstet Gynecol.* 2011 Dec;118(6):1454-8.

WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transexual People worldwide. WPATH website.

http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947. 2014. Accessed August 17, 2014.

Byne W, Bradley SJ, Coleman E, Eyler AE, Green R, Menvielle EJ, Meyer-Bahlburg HF, Pleak RR, Tompkins DA; American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. *Arch Sex Behav*. 2012 Aug;41(4):759-96.

Becker S, Bosinski HA, Clement U, et al. Standards for treatment and expert opinion on transsexuals. The German Society for Sexual Research, The Academy of Sexual Medicine and the Society for Sexual Science [in German]. *Fortschr Neurol Psychiatr*. 1998;66:164 – 169.

Beemer BR. Gender dysphoria update. *J Psychosoc Nurs Ment Health Serv*. 1996;34(4):12 – 19.

Bradley SJ, Zucker KJ. Gender identity disorder: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry*. 1997;36:872 – 880.

Breton J, Cordier B. Psychiatric aspects of transsexualism [in French]. *Bull Acad Natl Med*. 1996;180:1389 – 1394.

Brown GR. A review of clinical approaches to gender dysphoria. *J Clin Psychiatry*. 1990;51:57 – 64.

Cohen-Kettenis PT, Kuiper AJ, Zwaan WA, et al. Transsexualism: II. Diagnosis: the initial, tentative phase. *Ned Tijdschr Geneesk*. 1992;136:1895 – 1897.

Cole CM, Emory LE, Huang T, et al. Treatment of gender dysphoria (transsexualism). *Tex Med*. 1994;90(5):68 – 72.

Definitions of Medical Terms and Diagnostic Criteria for Gender Identity Disorder. Vancouver: The Zenith Foundation; 2003.

Eldh J, Berg A, Gustafsson M. Long-term follow up after sex reassignment surgery. *Scand J Plast Reconstr Surg Hand Surg*. 1997;31:39 – 45.

Wilczynski C, Emanuele MA. Treating a transgender patient: overview of the guidelines. *Postgrad Med*. 2014 Nov;126(7):121-8

Coleman e, Bockting w, Botzer m, et. Al, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, World Professional Association for Transgender Health (WPATH) Version 7, 2012. www.wpath.com (accessed April 22, 2015)

Gooren LJ. Transsexualism: I. Description, etiology, management. *Ned Tijdschr Geneeskd.* 1992;136:1893 – 1895.

Hage JJ. Medical requirements and consequences of sex reassignment surgery. *Med Sci Law.* 1995;35:17 – 24.

Landen M, Walinder J, Lundstrom B. Clinical characteristics of a total cohort of female and male applicants for sex reassignment: a descriptive study. *Acta Psychiatr Scand.* 1998;97:189 – 194.

Luton JP, Bremont C. The place of endocrinology in the management of transsexualism [in French]. *Bull Acad Natl Med.* 1996;180:1403 – 1407.

Mate-Kole C. Sex reassignment surgery. *Br J Hosp Med.* 1989;42:340.

Midence K, Hargreaves I. Psychosocial adjustment in male-to-female transsexuals: an overview of the research evidence. *J Psychol.* 1997;131:602 – 614.

Monstrey S, Hoebeke P, Dhont M, et al. Surgical therapy in transsexual patients: a multi-disciplinary approach. *Acta Chir Belg.* 2001;101:200 – 209.

Schlatterer K, von Werder K, Stalla GK. Multistep treatment concept of transsexual patients. *Exp Clin Endocrinol Diabetes.* 1996;104:413 – 419.

Schlatterer K, Yassouridis A, von Werder K, et al. A follow-up study for estimating the effectiveness of a cross-gender hormone substitution therapy on transsexual patients. *Arch Sex Behav.* 1998;27:475 – 492.

Smith YL, Cohen L, Cohen-Kettenis PT. Postoperative psychological functioning of adolescent transsexuals: a Rorschach study. *Arch Sex Behav.* 2002;31:255 – 261.

Smith YL, van Goozen SH, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry.* 2001;40:472 – 481.

Snaith RP, Hohberger AD. Transsexualism and gender reassignment. *Br J Psychiatry.* 1994;165:418 – 419. Specialty-matched clinical peer review.

The Endocrine Society issued Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, September 2009 (Hembree et al., 2009).

Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2009 Sep;94(9):3132-54.

The Harry Benjamin International Gender Dysphoria Association. Standards Of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons, 6th ed. 2001.

<http://www.wpath.org/Documents2/socv6.pdf>. Accessed June 20, 2013.

Van Kesteren PJ, Asscheman H, Megens JA, Gooren LJ. Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clin Endocrinol (Oxf)*. 1997 Sep;47(3):337-42.

World Professional Association for Transgender Health (WPATH). Standard of Care (SOC) Version 7; 2012.

Peer-reviewed references:

Bockting W, Goldberg J, eds. *Guidelines for Transgender Care*. Haworth Press; 2006.

Bockting W, Knudson G, Goldberg J. Counselling and mental health care of transgender adults and loved ones. Vancouver Coastal Health; 2006.

Coleman, E., Bockting, W, Botzer, M., et al. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism*. 2011;13:165 – 232. ISSN: 1553-2739 print/1434-4599 online. DOI: 10.1080/15532739.2011.700873.

de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011 Aug;8(8):2276-83.

Gojar C. Standards Of Care For Harry Benjamin Syndrome. The Original Benjamin Syndrome Site website. <http://www.shb-info.org/id34.html>. Accessed July 2, 2014.

Hayes Inc. Directory, Hormone Therapy for the Treatment of Gender Dysphoria. May 19, 2014. <https://www.hayesinc.com/subscribers/subscriberArticlePDF.pdf?articleId=16619>. Accessed July 9, 2014.

Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. Endocrine Society. 2009.

Lawrence AA. Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Arch Sex Behav*. 2003;32:299 – 313.

Lundström B, Pauly I, Wålinder. Outcome of sex reassignment surgery. *J Acta Psychiatr Scand*. 1984 Oct;70(4):289 – 94. PMID: 6388248.

Meyer W, Bockting WO, Cohen-Kettenis P, et al. The World Professional Association for Transgender Health's/The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version. WPATH, 2001.

Midence K, Hargreaves I. Psychosocial adjustment in male-to-female transsexuals: An overview of the research evidence. *J Psychol*. 1997;131(6):602 – 614.

[Moore E](#), [Wisniewski A](#), [Dobs A](#). Endocrine Treatment of Transsexual People: A review of Treatment Regimens, Outcome, and Adverse Effects. *J Clin Endocr Metab*. 2003 Aug 1;88(8). doi.org/10.1210/jc.2002-021967.

Sohn M, Bosinski HA. Gender identity: diagnostic and surgical aspects. *J Sex Med*. 2007 Sep;4(5):1193 – 207; quiz 1208. Review. PMID:17727344[PubMed — indexed for MEDLINE.

Selvaggi G, Bellringer J. Gender reassignment surgery: an overview. *Nat Rev Urol*. 2011 May;8(5):274 – 82. doi: 10.1038/nrurol.2011.46. Epub 2011 Apr 12. Review. PMID: 21487386.

Clinical trials:

Clinical Trials.gov Identifier: NCT02119377, received April 16, 2014 , updated and verified May 5, 2014. Curtin University of Technology. First Australian National Trans Mental Health Study. <http://clinicaltrials.gov/ct2/show/NCT02119377?term=gender+dysphoria+and+surgery&rank=1>.

Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD):

NCD for Transsexual Surgery (140.3), publication number 13-3. Effective date of this version is longstanding national coverage determination and has not been published.

<http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=83&ncdver=1&SearchType=Advanced&CoverageSelection=National&NCSelection=CA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&KeyWord=Sex+reassignment&KeyWordLookUp=Doc&KeyWordSearchType=And&kq=true&bc=IAAABAAAAAAAAA%3d%3d&>. Accessed June 17, 2014.

Local coverage determinations (LCD):

No LCD was identified at the writing of this policy.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

NOTE: “C” indicates a covered service in Pennsylvania, in accordance with this clinical policy requirement. “NC” indicates a service not covered in Pennsylvania.

CPT Code	Description	Comment
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	NC
11951	Subcutaneous injection of filling material (eg, collagen); .1 to 5.0 cc	NC
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	NC
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	NC
15775	Punch graft for hair transplant: 1 - 15 punch grafts	NC
15776	Punch graft for hair transplant; more than 15 punch grafts	NC
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	NC
15781	Dermabrasion; segmental, face	NC
15782	Dermabrasion; regional, other than face	NC
15786	Abrasion, single lesion (eg., keratosis, scar)	NC
15787	Abrasion; each add'l 4 lesions or less	NC
15788	Chemical peel, facial; epidermal	NC
15789	Chemical peel, facial; dermal	NC
15792	Chemical peel, non-facial; epidermal	NC
15793	Chemical peel, non-facial; dermal	NC
15820	Blepharoplasty, lower eyelid	NC
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad	NC
15822	Blepharoplasty, upper eyelid	NC
15823	Blepharoplasty, upper eyelid with extensive skin weighting down lid	NC
15824	Rhytidectomy; forehead	NC
15825	Rhytidectomy; neck with platysmal tightening	NC
15826	Rhytidectomy; glabellar frown lines	NC
15828	Rhytidectomy; cheek, chin, and neck	NC
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	NC
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	NC

15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	NC
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	NC
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	NC
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	NC
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	NC
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	NC
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	NC
15876	Suction assisted lipectomy; head and neck	NC
15877	Suction assisted lipectomy; trunk	NC
15878	Suction assisted lipectomy; upper extremity	NC
15879	Suction assisted lipectomy; lower extremity	NC
17380	Electrolysis epilation, each 30 minutes	NC
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	C
19303	Mastectomy, simple, complete	C
19304	Mastectomy, subcutaneous	C
19316	Mastopexy	C
19324	Mammoplasty, augmentation; without prosthetic implant	C
19325	Mammoplasty, augmentation; with prosthetic implant.	C
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.	C
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.	C
19350	Nipple/areola reconstruction.	C
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	C
19380	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	C
21083	Impression and custom preparation; palatal lift prosthesis	NC
21087	Impression and custom preparation; nasal prosthesis	NC
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	NC
21121	Genioplasty; sliding osteotomy, single piece	NC

21122	Genioplasty; sliding osteotomies, 2 or more osteotomies	NC
21123	Genioplasty; sliding, augmentation with interpositional bone grafts	NC
21125	Augmentation, mandibular body or angle; prosthetic material	NC
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional	NC
21137	Reduction forehead; contouring only	NC
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograf	NC
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction; without bone graft	NC
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	NC
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	NC
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction,	NC
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	NC
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	NC
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	NC
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	NC
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autograft)	NC
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autograft)	NC
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	NC
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	NC
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	NC
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	NC
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	NC
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	NC
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	NC

21209	Osteoplasty, facial bones; reduction	NC
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	NC
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	NC
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	NC
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	NC
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	NC
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	NC
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	NC
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	NC
21270	Malar augmentation, prosthetic material	NC
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	NC
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	NC
30420	Rhinoplasty, primary; including major septal repair	NC
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	NC
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	NC
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	NC
31750	Tracheoplasty; cervical.	NC
53430	Urethroplasty, reconstruction of female urethra.	C
31587	Under repair procedures on the Larynx	C
54120	Amputation of penis; partial	C
54125	Amputation of penis; complete.	C
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach.	C
54660	Insertion of testicular prosthesis (separate procedure).	C
54690	Laparoscopy, surgical; orchiectomy.	C
55150	Resection of scrotum.	C
55175	Scrotoplasty; simple.	C
55180	Scrotoplasty; complicated.	C

55970	Intersex surgery; male to female.	C
55980	Intersex surgery; female to male.	C
56620	Vulvectomy simple; partial.	C
56625	Vulvectomy simple; complete.	C
56800	Plastic repair of introitus.	C
56805	Clitoroplasty for intersex state.	C
56810	Perineoplasty, repair of perineum, nonobstetrical	C
57106	Vaginectomy, partial removal of vaginal wall.	C
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy).	C
57110	Vaginectomy, complete removal of vaginal wall.	C
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy).	C
57291	Construction of artificial vagina; without graft.	C
57292	Construction of artificial vagina; with graft.	C
57335	Vaginoplasty for intersex state.	C
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure).	C
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s).	C
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s).	C
58260	Vaginal hysterectomy, for uterus 250 g or less.	C
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s).	C
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele.	C
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele.	C
58275	Vaginal hysterectomy, with total or partial vaginectomy.	C
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele.	C
58290	Vaginal hysterectomy, for uterus greater than 250 g.	C
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	C
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele.	C
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele.	C

58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less.	C
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).	C
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g.	C
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	C
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less.	C
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).	NC
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g.	C
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	Not an active code
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less.	C
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).	C
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g.	C
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	C
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy).	C
67900	Repair of brow ptosis (supraciliary, mid-forehead, or coronal approach)	C
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	C
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	C
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	C
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	C
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	C
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg., Fasanella-Servat type)	C
69300	Otoplasty, protruding ear, with or without size reduction	C

ICD-10 Code	Description	Comment
F64.1	Gender identity disorder in adolescence and adulthood	