

## Benefit Coverage

<b>Covered Benefit for lines of business including:</b>
Health Benefits Exchange (HBE), Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Medicare-Medicaid Plan (MMP) Integrity
<b>Excluded from Coverage:</b>
Extended Family Planning (EFP)

## Description

The Diagnostic and Statistical Manual-Fifth Edition (DSM V) defines gender dysphoria as follows: “Gender dysphoria refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available.”

The World Professional Association for Transgender Health (WPATH) (<http://www.wpath.org>) is an international, inter-disciplinary organization, which publicizes evidence-based care and clinical guidance in its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7<sup>th</sup> Version (SOC)*. SOC is the primary reference for this policy.

Individuals, whose birth-assigned gender is male and who have gender dysphoria, are referred to as **transwomen**.

Individuals, whose birth-assigned gender is female and who have gender dysphoria, are referred to as **transmen**.

## Coverage Determination

<b>Authorization NOT Required</b>	<p><b>Services for Members Less than 18 Years of Age:</b></p> <ol style="list-style-type: none"> <li>Behavioral and medical health</li> </ol> <p><b>Services for Members 18 Years of Age and Older:</b></p> <ol style="list-style-type: none"> <li>Behavioral and medical health</li> <li>Laboratory testing to monitor treatment of gender dysphoria</li> <li>Pharmacological and Hormonal therapy (Prior authorizations unrelated to the treatment of Gender Dysphoria may be required.)</li> </ol>
<b>Requires Authorization</b>	<p><b>Services for Members Less than 18 Years of Age:</b></p> <ol style="list-style-type: none"> <li>Pharmacological and hormonal therapy that is non-reversible and/or produces masculinization or feminization</li> <li>Pharmacological and hormonal therapy to delay physical changes of puberty</li> </ol> <p><b>Services for Members 18 Years of Age and Older:</b></p> <ol style="list-style-type: none"> <li>Surgical treatment (outlined below)</li> </ol>

Surgical Treatment for Gender Dysphoria:

The following are covered when Criteria for Surgical Treatment for Gender Dysphoria have been met.

▶ **Surgical Treatment for Gender Dysphoria, Gender Reassignment Surgery for Members Less than 18 Years of Age is NOT covered.**

Female to male (FTM, transmen)		Male to female (MTF, transwomen)	
Breast reconstruction (e.g., mastectomy)	(19303-19304), reduction mammoplasty (19318)	Orchiectomy	54520, 54690
Hysterectomy	58150, 58262, 58291, 58552, 58554, 58571, 58573	Penectomy	54125
Hysterectomy Salpingo-oophorectomy	58661	Vaginoplasty	57335
Colpectomy/Vaginectomy	57110	Colovaginoplasty	57291-57292
Metoidioplasty	55899	Clitoroplasty	56805
Phalloplasty	55899	Labiaplasty	58999
Urethroplasty	53430	Tracheal shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage	31899
Scrotoplasty	55175, 55180	Breast Augmentation- Requires documentation by the physician prescribing hormones and the surgeon that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role	19324-19325.

**Authorization Forms**

Please access Prior Authorization forms by visiting Neighborhood's website at [www.nhpri.org](http://www.nhpri.org).

1. Go to the section for Providers
2. Click on "Resources & FAQ's"
3. Click on "Medical Management Request Forms"- forms are listed alphabetically by program.

[Prior Authorization Forms](#)

For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060. Fax authorization forms to 401-459-6023.

**For More information on Coding please reference the [Authorization Quick Reference Guide](#)**

### Criteria

Gender reassignment surgeries/procedures listed in Tables I and II require prior authorization and are covered for transmen or transwomen when documentation submitted confirms that all of the following criteria are met:

- Member is 18 years of age or older
- Member has the capacity to make fully informed decisions including consent to treatment.
- Gender Dysphoria has been diagnosed by qualified health provider(s) and is a persistent diagnosis
- Member has successfully lived full-time in the desired gender role without retuning to the original gender for a minimum of 12 months.
- Face to face comprehensive evaluation and treatment plan by the provider administering hormonal therapy and by the \*surgeon performing requested surgery.
- A behavioral health evaluation, supporting candidacy for gender-confirming surgery, performed within 6 months of the request for authorization for surgery.
- Attestation that the member is adhering to medical and behavioral health treatment as recommended and is medically and behaviorally stable.
- Attestation that the member has access to primary care provided by a clinician who has an understanding of gender dysphoria and who can perform and coordinate follow up care including appropriate screenings and monitoring.
- The treatment plan must conform to WPATH standards and/or to other evidence-based, agreed-upon, external guidelines.
- \* Surgeons must have demonstrated training, experience, and proficiency in performing the requested surgical procedure.
- Breast Augmentation mammoplasty requires documentation by the physician prescribing hormones and the surgeon that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role.

### Exclusions

- Surgical Treatment for Gender Dysphoria, Gender Reassignment Surgery for **Members Less than 18 Years of Age**
- Reversal of gender reassignment surgery or reversal of surgery to revise secondary sex characteristics.
- Gender reassignment services for members who are dissatisfied with their assigned gender in the absence of clinically significant distress or impairment.
- Procedures for the preservation of fertility such as the procurement, preservation, and storage of sperm, oocytes, or embryos.
- Procedures designed to enhance masculinity or femininity or to alter body contours for aesthetic reasons are considered cosmetic and are excluded.
- **Excluded procedures include but are not limited to the following:** Cosmetic Surgeries and Procedures (Refer to CMP Plastic Surgery), Dermabrasion, Hair transplants, Hair removal (including electrolysis epilation), Lipectomy, Osteoplasty - facial bone reduction, Otoplasty, Rhinoplasty, Rhytidectomy, Scar Revision, Subcutaneous injection of filling material, Tattooing or tattoo removal (except tattooing of the nipple/areola related to a mastectomy), Voice modification surgery

**Covered CPT codes when meeting criteria:**

<b>19301</b>	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)	<b>57106</b>	Vaginectomy, partial removal of vaginal wall
<b>19303</b>	Mastectomy, simple, complete	<b>57107</b>	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
<b>19304</b>	Mastectomy, subcutaneous	<b>57110</b>	Vaginectomy, complete removal of vaginal wall
<b>19316</b>	Mastopexy	<b>57111</b>	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
<b>19324</b>	Mammoplasty, augmentation; without prosthetic implant	<b>57291</b>	Construction of artificial vagina; without graft
<b>19325</b>	Mammoplasty, augmentation; with prosthetic implant	<b>57292</b>	Construction of artificial vagina; with graft
<b>19350</b>	Nipple/areola reconstruction	<b>57335</b>	Vaginoplasty for intersex state
<b>31899</b>	Unlisted procedure, trachea, bronchi	<b>58150</b>	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
<b>53430</b>	Urethroplasty, reconstruction of female urethra	<b>58180</b>	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
<b>54125</b>	Amputation of penis; complete	<b>58260</b>	Vaginal hysterectomy, for uterus 250 g or less
<b>54520</b>	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	<b>58262</b>	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
<b>54690</b>	Laparoscopy, surgical; orchiectomy	<b>58275</b>	Vaginal hysterectomy, with total or partial vaginectomy
<b>55175</b>	Scrotoplasty; simple	<b>58280</b>	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
<b>55180</b>	Scrotoplasty; complicated	<b>58285</b>	Vaginal hysterectomy, radical (Schauta type operation)
<b>56625</b>	Vulvectomy simple; complete	<b>58290</b>	Vaginal hysterectomy, for uterus greater than 250 g
<b>56810</b>	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	<b>58291</b>	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
<b>58541</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less	<b>58550</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
<b>58542</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	<b>58552</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
<b>58543</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g	<b>58553</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
<b>58544</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with	<b>58554</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

**Covered ICD 10 codes when meeting criteria:**

Description	ICD-10 Diagnosis	ICD-10 Procedure	CPT
<b>Surgical Services-Transgender Inpatient</b>	F64.1, F64.2, F64.8, F64.9, Z87.890	0HTT0ZZ,0HTU0ZZ, 0HTV0ZZ, 0H0T0ZZ, 0H0U0ZZ, 0H0V0ZZ, 0HBT0ZZ, 0HBU0ZZ, 0HBV0ZZ, 0TQD0ZZ, 0TUD07Z,0VQ50ZZ, 0VU507Z, 0UB04ZZ, 0UB14ZZ, 0UB24ZZ, 0UB54ZZ, 0UB64ZZ, 0UB74ZZ, 0UTG0ZZ, 0UT00ZZ, 0UT07ZZ, 0UT17ZZ, 0UT27ZZ, 0UT57ZZ, 0UT67ZZ, 0UT77ZZ, 0UT97ZZ, 0UTC7ZZ, 0UT04ZZ, 0UT14ZZ, 0UT24ZZ, 0UT54ZZ, 0UT64ZZ, 0UT74ZZ, 0UT94ZZ, 0UTC4ZZ, 0UT10ZZ, 0UT20ZZ, 0UT50ZZ, 0UT60ZZ, 0UT70ZZ, 0UT90ZZ, 0UTC0ZZ, 0UT9FZZ, 0UB014ZZ, 0UB74ZZ, 0H0T0ZZ, 0HQ70ZZ, 0HQU0ZZ, 0HQV0ZZ, 0H0T0JZ, 0H0U0JZ, 0H0V0JZ, 0HRT0JZ, 0HRU0JZ, 0HRV0JZ, 0HUT0JZ, 0HUU0JZ, 0HUV0JZ, 0VTS0ZZ, 0VTSXZZ, 0VR90JZ, 0VRB0JZ, 0VRC0JZ, 0VT90ZZ, 0VT94ZZ, 0VTB4ZZ, 0VTC4ZZ, 0VTB0ZZ, 0VTC0ZZ, 0W4M0Z0, 0W4M070, 0U7G0ZZ, 0UQG0ZZ, 0W8NXZZ, 0UBJ0ZZ, 0UBJXZZ, 0HST0ZZ, 0HSU0ZZ, 0HSV0ZZ, 0HSWXZZ, 0HSXXZZ, 0HRT07Z, 0HRU07Z, 0HRV07Z, 0HRW07Z, 0HRWX7Z, 0HRX07Z, 0HRXX7Z, 0UBMXZZ, 0UTM0ZZ, 0UQG7ZZ, 0UGGXZZ, 0UUG07Z, 0WQN0ZZ, 0UBG0ZZ, 0UTG7ZZ, 0UBG7ZZ, 0UQF7ZZ, 07TC0ZZ	19301, 19303, 19304, 19316, 19318,53430, 55175, 55180, 55899, 57110, 58150, 58262, 58291, 58552, 58554, 58571, 58573, 58661, 19324, 19325, 31899, 54125, 54520, 54690, 56805, 57291, 57292, 57335, 58999, 19350, 56625, 56800, 56810, 57106, 57107, 57111, 58180, 58260, 58275, 58280, 58285, 58290, 58541, 58542, 58543, 58544, 58550
<b>Surgical Services-Transgender Outpatient</b>	F64.1, F64.2, F64.8, F64.9, Z87.890		19301, 19303, 19304, 19316, 19318,53430, 55175, 55180, 55899, 57110, 58150, 58262, 58291, 58552, 58554, 58571, 58573, 58661, 19324, 19325, 31899, 54125, 54520, 54690, 56805, 57291, 57292, 57335, 58999, 19350, 56625, 56800, 56810, 57106, 57107, 57111, 58180, 58260, 58275, 58280, 58285, 58290, 58541, 58542, 58543, 58544, 58550

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**CMP Cross Reference:** CMP-012-Plastic Surgery  
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**Neighborhood reviews clinical medical policies on an annual base.**

**Disclaimer:**

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.

**References:**

The World Professional Association for Transgender Health (WPATH). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 7<sup>th</sup> Version. 2011. URL address: <http://www.wpath.org>

American Psychiatric Association. (May 2013). *Diagnostic and Statistical Manual of Mental Disorders*. 5<sup>th</sup> Edition (DMS 5). Arlington, VA: American Psychiatric Publishing.

RI EOHHS Gender Dysphoria/Gender-Nonconformity Guidelines. November 2015